B.C. CORRECTIONS

A STUDY OF SUICIDES, 1970 - 1980

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Abbreviations:

L.M.R.C.C.:	Lower Mainland Regional Correctional Centre, Burnaby, B.C.
West Wing	Remand and Sentenced Inmates
East Wing	Sentenced Inmates
South Wing	Maximum Security Inmates and Special Observation
Westgate 'A'	Segregation and Discipline Area
Westgate 'B'	Sentenced Inmates
L.W.C.C.:	Lakeside Correctional Centre for Women, Burnaby, B.C.
V.I.R.C.C.:	Vancouver Island Regional Correctional Centre, Victoria, B.C.
K.R.C.C.:	Kamloops Regional Correctional Centre, Kamloops, B.C.
P.G.R.C.C.:	Prince George Regional Correctional Centre, Prince George, B.C.
H.C.I.:	Haney Correctional Institution, Haney, B.C. (closed 1975)

INTRODUCTION

On July 13, 1981, the Commissioner of Corrections for British Columbia issued a Memorandum to the Director of Inspection and Standards calling for the formation of a Special Committee on Suicide Prevention for B.C.'s Correctional Centres.

The task of the Committee was to study the problem of suicides and attempted suicides in the system, review all relevant Branch policies and procedures as well as recommendations from Coroner's Inquests related to Branch suicides. These findings were then to be viewed in conjunction with conclusions from suicide studies in other jurisdictions to provide the best possible tactical information on this problem.

Finally, the Committee was directed, on the basis of this review:

> "To make recommendations with respect to changes in policy procedure or practice of the Corrections Branch which the Committee deems appropriate in order to prevent suicides to the greatest degree possible."

This report represents the data gathered from a ten year study of suicides in B.C. Correctional Institutions January 1, 1970 until Decembr 31, 1980, reviewing the available Branch policy and procedure, a compilation of Coroner's Recommendations and a review of material from other jurisdictions. Conclusions and recommendations are presented in summary.

HISTORICAL PERSPECTIVES

CANADIAN

Dr. Paul E. Termansen and Mr. R. Peters of Vancouver, in their recently published research paper "TRENDS IN THE DEMOGRAPHY OF SUICIDE IN CANADA" May 1982, have closely examined the increase in Canadian Suicide Rates.

The following 'Abstract' and graph provide a backdrop perspective to our research that follows:

ABSTRACT

> "Reported suicide in Canada has increased dramatically over the last 20 years, both in relative terms (as a proportion of all deaths) and in absolute terms (as an annual incidence rate per 100,000 in the general population). It is estimated that an average of more than two million years of life are prematurely lost to suicide per annum in Canada. Despite the consistently higher rates among men, the pace of this increase has been greater among women, as evidenced by significant reductions in the ratio of male-female suicide rates. The model age group includes people in the 40 to 64 year old range, with suicide rates declining both before and after middle age. The most pronounced relative increases are found, however, among the youngest age groups. The suicide rate among 10 to 19 year old males, for example, increased by some 750% over the last half a century. The older males, by comparison, show no significant changes in rates over these fifty-three years, while suicide among those aged 70 and over actually appears to be declining, but not markedly so."(1)

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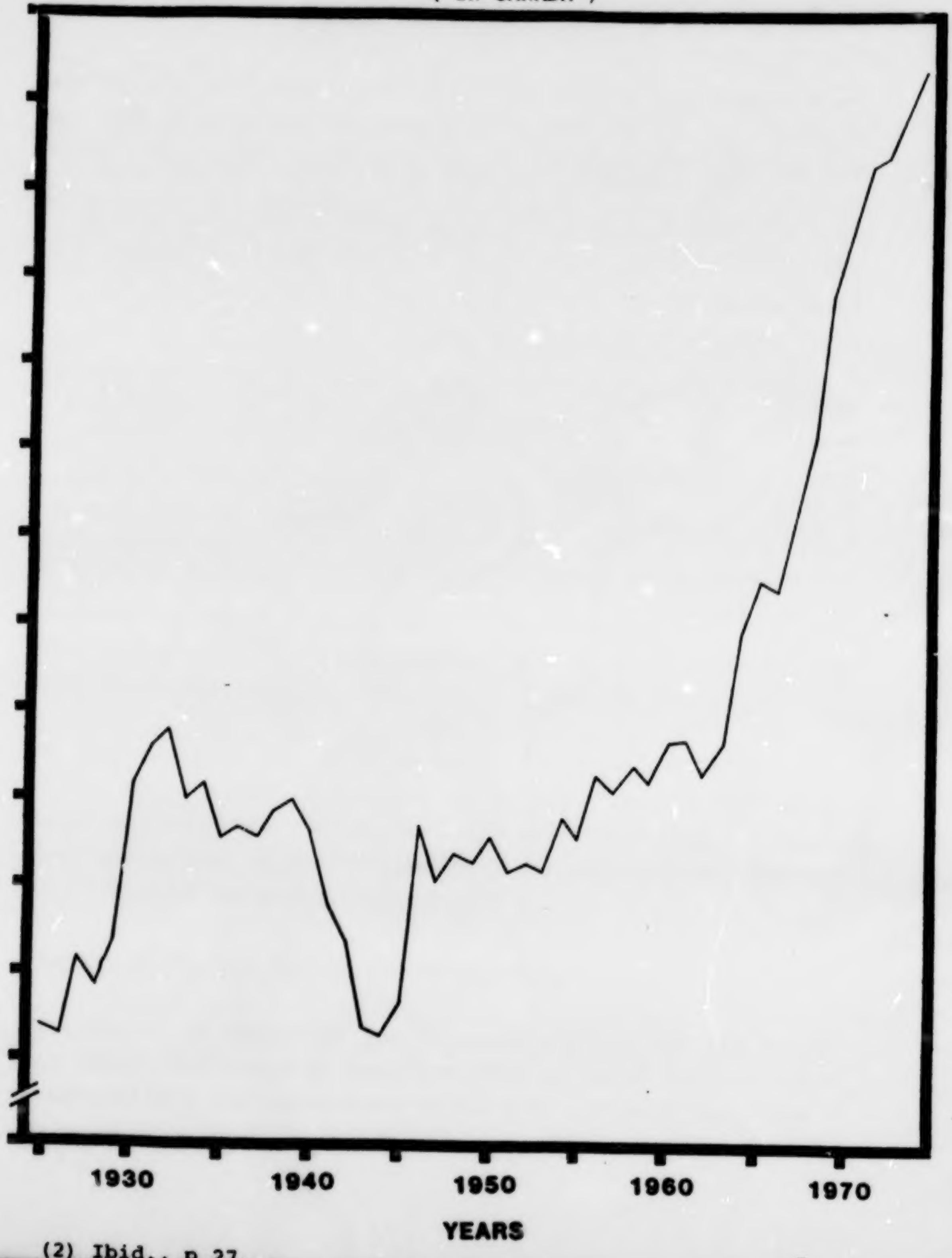
(1) Termanson, Dr. P., and Peters, R., "Trends in the Demography of Suicide in Canada", report submitted to the Canadian Task Force on Suicides. Vancouver, 1982, pp. iii.

FIGURE I

Reprint from "Trends in the Demography of Suicide in Canada"

SUICIDES AS A PERCENTAGE OF ALL DEATHS
(IN CANADA)



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(2) Ibid., p 27.

HISTORICAL PERSPECTIVES

B.C. CORRECTIONS BRANCH

Persons involved in the Correctional process have always been plagued with the problem of suicides in Correctional Centres and pondered the ways and means to prevent these occurrences.

In B.C. Corrections, following a spate of suicides in the years 1974 - 1975, there began a ground swell of concern for identifying the precipitating causes and setting out to prevent these unfortunate events.

With the establishment of the Division of Inspection and Standards within the Corrections Branch in 1974, official inquiries were conducted into the events surrounding every inmate death prior to a Coroner's Inquest.

The examination and compilation of those inquiries culminate in this report.

METHODOLOGY

Ten Year Study:

Given the fact that file destruction has been under way for several years, institutions have opened/closed, and Inspection and Standards suicide files only commenced in 1974, a complex task surrounded the mere identification of the cases of suicide 1970 to 1980.

Individual institutions, personnel from institutions now closed and in some cases families were solicited for crucial information. We were fortunate indeed to have Mr. Bob Collins, former Director of LMRCC's West Wing, assist in this task as he closely monitored the incidence of LMRCC suicides over the years, attended Coroner's Inquests and duly noted recommendations.

Coroner's Inquest reports were then sought in each case with the cooperation and assistance of B.C.'s Chief Coroner, Mr. Bob Galbraith and his staff, notably Mrs. Norma Ferguson.

A questionnaire was developed, initially as a data gathering tool, in an effort to factor out significant information from each of the cases. This has been easily modified for present and future use in documenting suicides and suicide attempts for research purposes.(Appendix A)

Review of Branch Policy and Procedures:

The Manual of Standards for B.C. Corrections and the Manual of Adult Institutional Services were reviewed for any and all instructions and references to suicide and self-inflicted injury. The focus was a search for procedures in responding to, handling and reporting incidents of this nature.

As a second phase of this review, a survey was taken of the policies and procedures, formal and informal, which were and are operational in the various institutions in the B.C. Correctional system. For this information a request for any local written policy was mailed to each facility and the results collated.

Coroner's Inquests and Recommendations:

In many of the cases following 1974, Coroner's Inquest Reports were found in Inspection and Standards files, but in some cases, particularly those pre-dating 1974, there were only the Coroner's recommendations. To ensure all available detail was obtained, complete inquest reports were copied, obtained from LMRCC in some instances, or otherwise secured for permanent referral.

A review of the action taken in response to Coroner's recommendations was also attempted with reasonable success,given available data. A permanent procedure for review of response taken to Coroner's Inquests and this Division's investigations into such events, has been implemented.

Review of Studies by Other Jurisdictions

In looking toward other provincial jurisdictions, Ontario, Manitoba, Saskatchewan and Alberta responded to our request indicating that there were no other research projects of this nature currently underway or available from recent years that could be of value for our purposes.

Quebec, however, has just completed a related study covering the 5-year period 1975-1980 (March 1982). Their study, prompted by Quebec Coroner's Inquest recommendations, is currently being forwarded for translation which we hope to have for comparison before the closure of this project.

Our best sources of comparative data have come from the recently completed Corrections Service of Canada study "SELF INFLICTED INJURIES AND SUICIDES" (August 1981) and the American Study "AND DARKNESS CLOSES IN ...A NATIONAL STUDY OF JAIL SUICIDES" (October 1981). Statistics and tables from these studies will be presented throughout this report for comparative purposes.

Conclusions from Corrections Service Canada research are presented in Appendix I.

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INMATE SUICIDE VICTIM

Theoretical Construct B.C. Corrections
1970 - 1980

Based on the ten year data, we have developed a theoretical construct of the suicide victim in our system. Caution with interpretation is necessary as it must be remembered that the following profile cannot be taken as a rule but as a product of a series of averages taken from our Branch statistics over ten years.

> Our theoretical victim is a 30-year old single caucasion male born out of Province or from a rural area of B.C. and having few if any community resources.
>
> He will be on remand status facing charges involving property offences and will be held in L.M.R.C.C.'s West Wing. He will have served between 25 and 35 days in custody awaiting trial.
>
> Our victim will commit suicide between midnight and 3:00 a.m. on a Sunday morning most likely in the early Spring (March - May). He will use bedding or clothing to hang himself from cell bars and will be found within 60 to 75 minutes of being last seen alive by staff making rounds.
>
> He will likely have a previous history of attempts and threats of suicides although staff may or may not be aware of this. If fellow inmates are aware of his previous attempts or threats they will not disclose this knowledge or alert staff prior to the fatal attempt.
>
> A psychiatric history will likely be found which staff may or may not be aware of. The motive for suicide will most often be separation from or "loss" of a significant person.

CONCLUSIONS

CONCLUSIONS

Suicide Rates:

1. While there appears to be a slowly raising suicide rate for Canada and B.C., there is no clear trend for suicides in B.C. Correctional Centres. The suicide rate fluctuates quite erratically for our Correctional Institutions with several years shown on a par with National and B.C. rates, approximately half the years significantly above but several years below the rates of the country and the province.

   Considering that the majority of inmates in the system are drawn from, and housed in, that area of the country with the highest suicide rate (B.C. Lower Mainland) some might believe it surprising that the suicide rates for B.C. Corrections are not higher.

Age:

2. The age of an inmate does not provide any significant indicator of suicide risk.

   It appears safe to say that suicides not only occur in all age groups in B.C.'s inmate community, but from our findings, the rate of occurance roughly approximates the proportion of inmates found in those age groups in relation to the total inmate populations.

Sex:

3. The incidence of female suicide in our Correctional Centres appears closely related to their proportion of total inmate population and thus sex cannot be considered a significant factor in predicting suicidal behaviour or assessing suicidal risk.

   Aside from our overall need for careful assessment and special handling of those individuals designated as presenting a suicidal risk, we have no recommendations for unusual or unique prevention programs based on the sex of an inmate.

4. Place Of Birth:

   We cannot draw any inferences from our data relative to Place of Birth in relation to the incidence of suicide in our Correctional Centres; however, officers could be alerted to the significance of geographical and cultural dislocation particularly when combined with presence of other destructive factors.

   The transient individual on remand with no local support is psychologically vulnerable particularly if he faces serious charges and has few resources. This may be an alert for staff.

Nationality:

5. Despite the apparent limited numbers of foreign nationals in our institutions and the difficulty of identifying

those individuals, the proportion of suicides in this group suggests that those on immigration detention are somewhat more vulnerable to suicide than the general inmate population.

Depending on the seriousness of the charges awaiting a foreign national facing deportation and/or depending on his feelings of anxiety concerning the severing of current Canadian ties or disruption of life, we may have a potential suicide candidate.

The key would appear to be exercising care in assessing all individuals on "Immigration Hold" or facing immediate deportation.

Where suicide potential is identified, Correctional Staff should advise and liase closely with the Courts and lawyers to be aware of significant developments.

Race - Ethnic Background:

6. Clearly, the factors of the race and ethnic background of our suicide victims are of little value in providing an indicator of suicide potential.

It appears from our B.C. Corrections data, that as far as native offenders are concerned, there are not a disproportionate number of their group suiciding in our institutions.

Marital Status

7. While marital status alone is by no means a factor which indicates potential for suicide, it can be indicative of important community relationship support or lack thereof.

Intelligence:

8. It appears clear that we are unable to use the factor of intelligence to assist in predicting suicidal behaviour in B.C. Corrections even if reliable I.Q. scores were available at the time of admission.

Religion:

9. From data available, there can be no indicators of suicide potential drawn from an examination of an inmate's religious affiliation.

Type Of Offence:

10. While type of offence gives no definitive indicator vis-a-vis suicide potential, we do see in our B.C. institutions, a higher rate of suicide among violent offenders with murderers having a particularly high incidence.

Clearly, if other suicide danger signals are present, the violent offender, particularly the inmate charged with murder or facing a possible life term, deserves special watching from a suicide prevention point of view.

Psychiatric History

11. It would appear, evidence of a previous psychiatric history could be one of a very few indicators of an increased potential for suicide.

Of key importance is obtaining background information on the previous psychiatric histories on inmates who are currently experiencing anxiety or displaying serious upset.

Training all staff in the basics of recognizing symptoms of stress, anxiety and/or mental illness will be a necessary key for effective operation of a suicide prevention program.

Consideration be given to having guaranteed beds at the Forensic Psychiatric Hospital to ensure immediate transfer of commitable patients or alternatively establishing under Corrections a separate medical/psychiatric facility for observation, assessment and care of suicidal, psychotic and observation inmates.

Suicide Attempts:

12. There are many more attempted suicides than actual suicides.

Many attempted suicides are planned, non-lethal events quite often designed for attention getting or other manipulative purposes such as securing transfer or gaining relief from an anxiety producing situation.

There are strong indicators that successful suicides were preceded by attempts and in some cases many attempts by the victim.

Every attempted suicide must, therefore, be looked at as serious.

The importance of accurate reporting of incidents of self-destructive behaviour and attempts at suicide on "Report of Inmate Injury" form is essential in the process of analyzing and gaining an understanding of destructive behaviour in our institutions.

Precipitating Event:

13. Given many difficulties in assessing suicide motivation, we are still able to roughly rank the most important motivating factors, as:
    (1) loss of significant person(s);
    (2) fear, anger;
    (3) drug reaction, alcohol reaction, current psychiatric problems;
    (4) remorse/disgrace, poor self-concept; and
    (5) deterioration of health.

Correctional staff while realizing motivational factors may be different for each inmate in their care,(masked or identifiable) may nevertheless be sensitized to the importance of communicating with their inmate charges to constantly assess mood, problems, anxieties and concerns.

Correctional staff, on recognizing the potential motivators, can make the single most important contribution in suicide prevention by discussing the inmate's problems, concerns, anxieties and neutralizing where possible or referring for special services.

Status Before The Court:

14. In regard to status before the Court we can readily see 70% of our inmate suicides occur in the remand group which accounts for only 40% of our inmate population. Therefore, it would appear that our remand inmates are in much greater jeopardy from a suicide standpoint.

Suicide intervention programs would best be initially aimed at the remand population and the dynamics at work in the remand inmate groups. Therefore, a focal point in our immediate suicide prevention program should centre on the new Vancouver Pretrial Services facility.

All remand staff at the Pretrial Services Centre should be trained and certified in first aid, C.P.R., and receive the most advanced training available in suicide prevention techniques.

Time Served Since Admission:

15. While there appears to be a higher incidence of suicides after three weeks of incarceration, there seems to be no time during a term of imprisonment that is safe from a suicide prevention stand point.

It would appear that there are a few suicides that occur during the initial entry stages (when presumeably observation is potentially best and the assessment process is still underway). However there are many suicides that occur when the victim could be considered to be over the hurdle of adjustment and these are quite unforseen by staff. Vigilance, again, is seen as the key of suicide prevention.

Stage Of Sentence:

16. Perhaps the only conclusions to be drawn regarding the factor of suicide by stage of sentence are that the preponderance of suicides occur in the remand stage. Suicides, thereafter, occur in all stages of the judicial and sentence process with the exception of the pre-release phase where suicides are rare.

Year:

17. While there is no predictable pattern of the incidence of suicide by year emerging from these figures, it does appear that years of low incidence can be followed by quick increases in absolute numbers with no gradual trends established.

Month:

18. Linked to the fact that peaks in our prison suicides occur during the months of March and September, it appears that remand inmates facing serious charges are in high stress situations and bear close staff observation from a suicide potential standpoint.

Day:

19. While the study showed Wednesdays and Sundays have higher incidence of suicides in B.C. Corrections, staff should be aware that there are really no safe days where suicide vigilance could be relaxed.

Time Of Day:

20. Because of the high incidence of suicides in the late evening and early morning hours, following midnight, it would seem important for staff members on these shifts to be watching for suicide clues and maintaining regular (or staggered) close visual checks of all inmates as frequently as possible.

    Inmates previously identified as upset or suicidal should be subject to the closest supervision possible during these time periods; with use of observation cells or moving the inmate to cells in closest proximity to the officer's station or within constant visual contact.

    When considering staff deployment in relation to suicide prevention, we would see the best time for increased coverage to be 0001 to 0300 hours. Alternatively, checks (counts) should be stepped up between 11 p.m. and 4 a.m.

    There appears no "safe" time of day from a suicide prevention standpoint, and thus constant vigilance is the best rule to follow.

Institution:

21. Suicide prevention programs would more effectively apply to maximum security facilities particularly focusing on areas of the institution housing remand prisoners.

Staff training in suicide prevention should be properly focused on staff employed in maximum security Correctional Centres even though all staff should have an understanding of the dynamics of suicide, prevention techniques and the warning signs of suicide.

Type Of Cell:

22. In regard to type of cell; protective custody, observation and segregation areas have the highest suicide rates in proportion to the number of inmates housed in these areas.

The higher rates of suicide in protective custody, observation and segregation units, increases the need for better surveillance, careful staff selection and staff training for these areas.

Having noted the higher "rates" for suicide in protective custody observation and segregation areas, we are still faced with the fact that by far the greatest "number" of suicides occur in the general population cells. Thus, suicide can and will occur in any area of the institution making vigilance in all areas important.

Method:

23. In attempting to divert the suicidal inmate, less attention should be paid to physically restricting him from suicide by removal of all potential suicide implements and more attention should be paid to providing essential human interaction with staff or other inmates, to hopefully provide alternative solutions and services.

Time Lapse Till Discovery

24. Lapse time between the last "live" check by a staff member and discovery of the inmate victim averages close to an hour. With an hour being the mandatory standard for checking inmates in secure institutions, we conclude that an effective suicide prevention technique would be to increase the frequency and perhaps the quality of checks.

Perhaps electronic sensing devices may assist Correctional Officers in some instances in determining the difference between a sleeping inmate and one who is attempting suicide.

Clearly, an inmate displaying any danger signs from a suicide point of view, should be subjected to much closer surveillance.

It is possible other inmates can be a positive resource in suicide prevention; however, proper understanding on the part of staff and proper selection of inmates are essential.

TEN YEAR STUDY OF SUICIDES 1970 - 1980

B.C. CORRECTIONS

CHARACTERISTICS OF INMATE SUICIDE

PART I

OBITUARIES

OBITUARIES

STATISTICS - SUICIDES B.C. CORRECTIONAL INSTITUTIONS

January 1, 1970 - December 31, 1980

Jan. 11, 1970	HISTED, Robert	LMRCC West Wing
Oct. 19, 1970	ERDMAN, James Oliver	VIRCC
Aug. 25, 1971	ABBOTT, Steven	LMRCC West Wing
Mar. 18, 1972	FORTIER, Clyde Jeffrey	Haney C.C.
May 24, 1972	JENKINS, Roy John	LMRCC West Wing
Mar. 5, 1973	MacDONALD, Kenneth Allan	LMRCC South Wing
April 12, 1973	ENGELL, Leonard John	LMRCC West Wing
May 7, 1973	JINKERSON, Oliver	LMRCC South Wing
Feb. 17, 1974	BAUM, Henry	KRCC
Mar. 14, 1974	ZAVADIL, Vaclav	LMRCC West Wing
Mar. 26, 1974	HORWOOD, Michael R.	LMRCC West Wing
June, 9, 1974	COTE, Victorien	LMRCC East Wing
June 20, 1974	O'HARA, John Henry P.	ARCC
Sept. 24, 1974	CHRISTIE, Frederick R.	LMRCC South Wing
Apr. 20, 1975	KRAEMER, Helmut	ARCC
May 7, 1975	SACKVILLE, William R.	LMRCC South Wing
May 17, 1975	JENKINS, John Brady	VIRCC
Aug. 27, 1975	METOSOS, Dana	LMRCC West wing
Sept. 2, 1975	LEWICKIE, Louise Ann	Lakeside
Sept. 10, 1975	CUMPSTONE, Roger Miles	PGRCC
Sept. 15, 1975	BAILEY, Thomas James	PGRCC
Mar. 28, 1976	GLADEAU, Jeffrey Alfred	LMRCC West Wing
Dec. 20, 1976	PHILLIPS, Barry	LMRCC East Wing
Mar. 2, 1977	WEST, Hudson	LMRCC West Wing
Apr. 14, 1978	BONOGOFSKI, Robert A.	LMRCC West Wing
Apr. 19, 1978	BAKER, Mark Neil	LMRCC East Wing
July 18, 1978	ACERA, Mark Anthony	LMRCC Segregation
June 4, 1978	MARLOW, John	VIRCC
Sept. 22. 1978	BROWN, Paul Earl	LMRCC West Wing
Mar. 13, 1979	McDONALD, Steven D.	LMRCC West Wing
Mar. 30, 1979	CARGYLE, Richard Irving	LMRCC West Wing
Oct. 14, 1979	SPARVIER, Crawford	LMRCC West Wing
Nov. 23, 1979	SLOBODA, Garry	LMRCC Segregation
Nov. 16, 1980	RICHARDS, Maureen	Lakeside
Dec. 17, 1980	BAKY, Abdel	LMRCC South Wing

PART II

SUICIDE RATES

SUICIDE RATES

In light of Dr. Termanson's observations concerning the escalation of rates of suicide in Canada, it would appear important at the outset to review the suicide rate for B.C. Correctional Institutions against the backdrop of Provincial and Canadian data. When these rates are presented, Figure 2 (B.C. Male Population Suicide Rates vs Adult Inmates in B.C. Correctional Institutions) and Figure 3 (Canadian Male Suicide Rates compared with B.C. and Corrections), several interesting distinctions are noted:

Figure 2

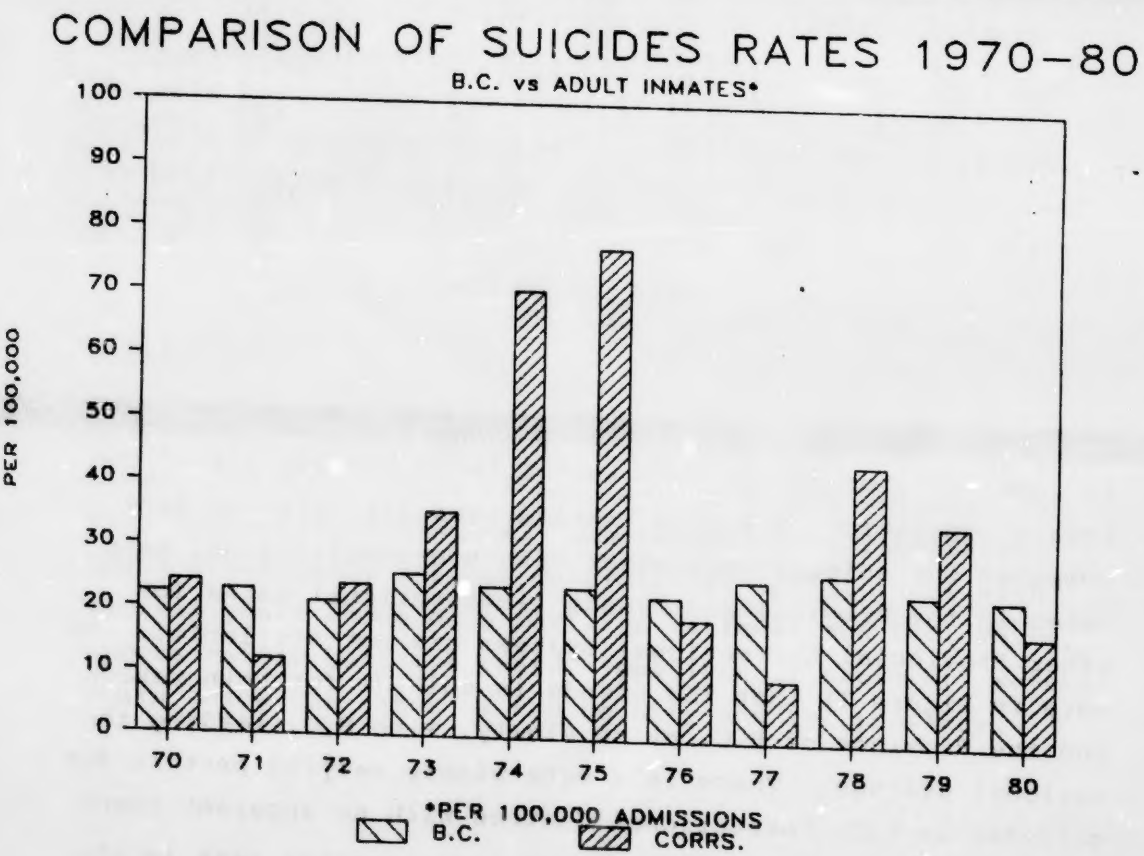
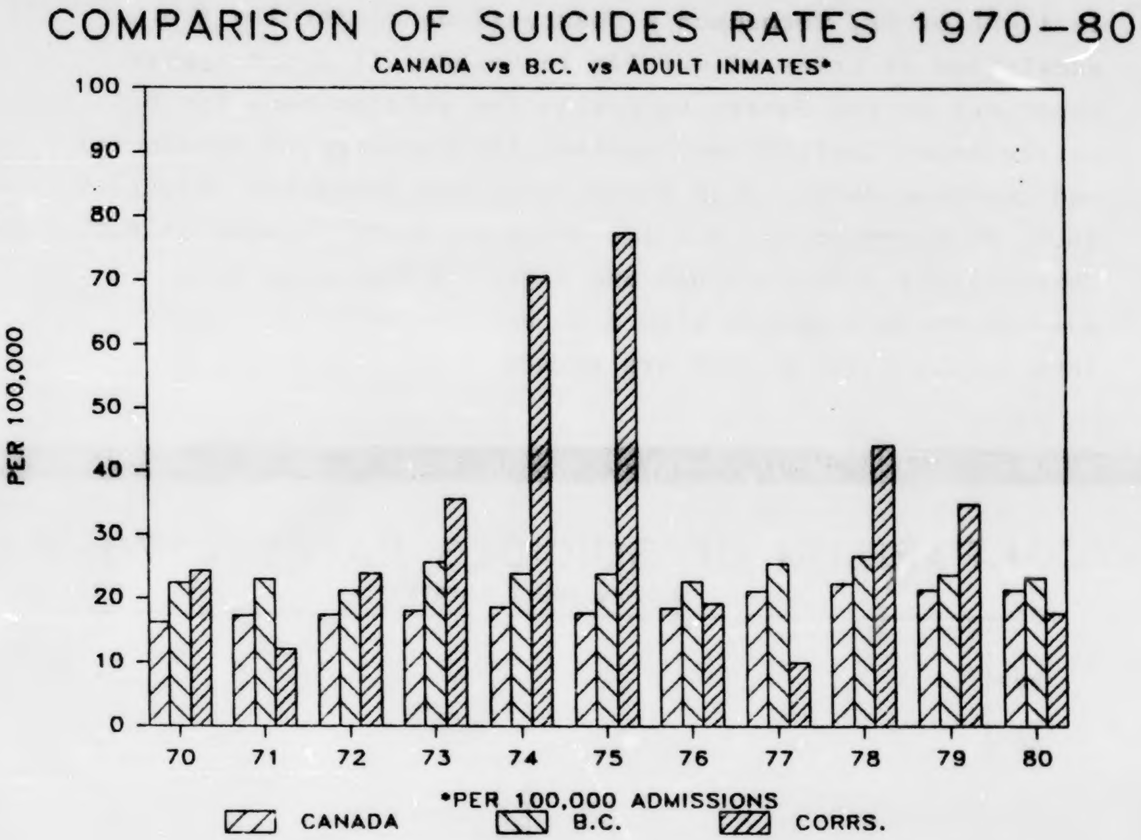


Figure 3



In consideration of the fact that between 93% and 96% of our inmate population in B.C.'s institutions are male, we have compared our suicide statistics with non-institutional male rates in the Province and Canada (institutional rates for other Provincial Correctional Systems are not available). We note in Figure II that the trends in suicide for both Canada and the Province of B.C. climb slowly, with B.C. leading the national average. There is a more widely varying pattern for suicides in B.C. Correctional Centres with no apparent trend except a peak in the years 1974-75 and a smaller peak in the years 1978-79. For two years, suicides in our institutions were roughly equivalent to the rate for B.C.'s male population. Even more startling is the discovery that in four of the years scrutinized, suicides in B.C.'s Correctional Centres were equal to, or lower than, the Canadian male suicide rate.

To place these rates in perspective, it is important to note that not only is the highest rate of suicide in the country found in B.C. but the Lower Mainland area of the province is the so called suicidal 'hot spot', giving it the dubious distinction of having the highest rate of suicide in Canada. Given that the majority of inmates in B.C. Corrections Centres are drawn from B.C.'s Lower Mainland area and are housed chiefly within institutions located in this same area, principally Burnaby's archaic L.M.R.C.C./ Oakalla Institution), perhaps it is not surprising that L.M.R.C.C. accounts for the largest concentration of B.C. Corrections inmates and correspondingly held 68.5% of the inmates who suicided over the 10-year period of our Study.

CONCLUSIONS:

While there appears to be a slowly rising suicide rate for Canada and B.C., there is no clear trend for suicides in B.C. Correctional Centres. The suicide rate fluctuates quite erratically for our Correctional Institutions with several years shown on a par with national and B.C. rates, approximately half the years significantly above but several years below the rates of the country and the province.

Considering that the majority of inmates in the system are drawn from, and housed in, that area of the country with the highest suicide rate (B.C. Lower mainland) some might believe it surprising that the suicide rates for B.C. Corrections are not higher.

PART III

PERSONAL HISTORY FACTORS

INCIDENCE OF SUICIDE BY AGE

All suicide studies invariably examine the important factor of age.

> "Past studies have shown that age is a significant factor in jail suicide. Danto found that 70% of the suicide victims were between the ages of 20 and 26 and Heilig found that 46.2% were between 20 and 29. Esparza found a mean of 28.6 years old, while Fawcett and Marrs found a mean of 33 years old."(3)

The age range and distribution in our B.C. Corrections study is displayed as follows with a Mean Age of 30 years. (Table 1)

Table 1

AGE DISTRIBUTION OF SUICIDES IN B.C. CORRECTIONAL INSTITUTIONS 1970-80

Under Age 20		Ages 20-29		Ages 30-39		Ages 40-49		Ages 50 Plus	
Age	Suicide	Age	Suicide	Age	Suicide	Age	Suicide	Age	Suicide.
15	-	20	2	30	1	40	-	50	-
16	-	21	3	31	1	41	-	51	-
17	3	22	2	32	3	42	-	52	-
18	1	23	3	33	1	43	2	53	-
19	-	24	3	34	-	44	-	54	-
		25	-	35	-	45	2	55	-
		26	-	36	-	46	1	56	-
		27	2	37	1	47	-	57	1
		28	-	38	1	48	-	58	-
		29	1	39	-	49	-	59	-
								60	-
								61	-
								62	-
								63	-
								64	-
Total	4 (11.4%)	Total	16 (45.7%)	Total	8 (22.8%)	Total	5 (14.3%)	Total	2 (5.7%)

Mean Age 29.94 years

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(3) Hayes, L. and Kajdan, J. "And Darkness Closes In...National Study of Jail Suicides" National Centre on Institutions and Alternatives, Wash, D.C. Oct. 1981, p.20

Knowing the age distribution of our suicide victims, it is important to consider the average age distribution in our inmate populations in order to determine if the occurance by age is significant.

While figures on age of population are not available for the ten year period, the averaging of available three year data yields a close approximation for our study.(Table 2)

Table 2

Age Distribution of Inmate Population in Relation to Age of Suicide Victims, B.C. Corrections 1970 - 1980

Age Group	1978-79	1979-80	1980-81	Average % Inmate Pop.	Suicides
Under 20	18.2%	18.3%	17.8% =	18.2%	11.4%
20 - 29	46.0%	47.0%	47.5% =	47.0%	45.7%
30 - 39	19.9%	19.8%	20.4% =	20.2%	22.8%
40 - 49	9.0%	8.7%	8.5% =	8.7%	14.3%
50 & over	5.9%	6.0%	5.7% =	5.9%	5.8%
% TOTAL	100%	100%	100%	100%	100%

For data see Appendix B

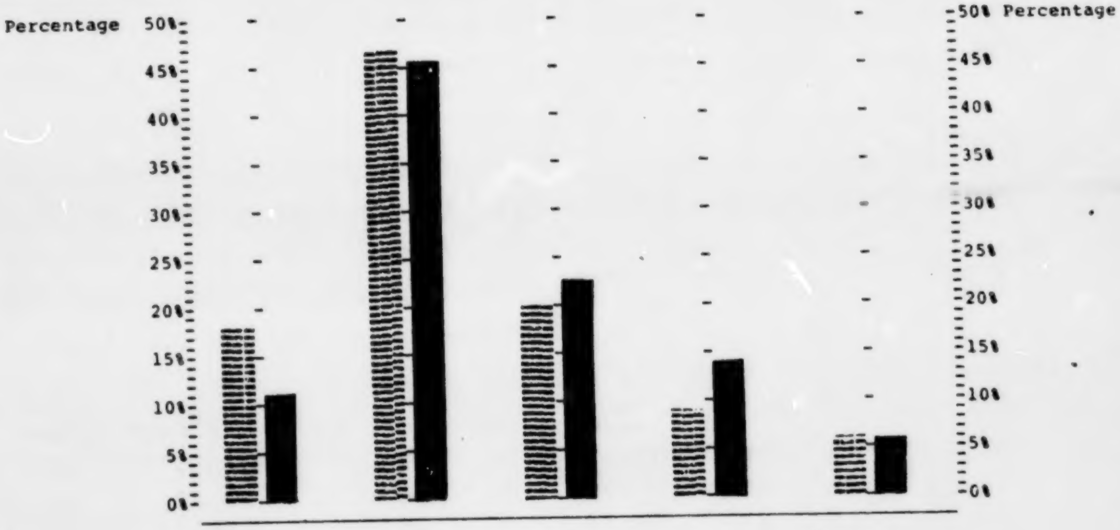
Our finding is that the percentage of suicides in a particular age group approximates the percentage of total inmate population in that same age group particularly in the 20 - 29 and 30 - 39 age groups. (Figure 4).

Figure 4

Figure 4

INCIDENCE OF SUICIDE B.C. CORRECTIONS BRANCH BY AGE IN RELATION TO PROPORTION OF INMATE POPULATION

1970 - 1980



Age Group	Under 20	20 to 29	30 to 39	40 to 49	50 and over
▨ Proportion of Inmate Population	18%	47%	20%	8.7%	5.9%
■ Proportion of Suicides	11.4%	45.7%	22.8%	14.3%	5.7%

The rate of suicide vis a vis the proportion of population is almost identical for the 'Ages 20 - 29' age group (45.7% to 47%) and again very close for the 'Age 30 - 39' group (22.8% to 20%). The rate of suicides in the 'Forty' age group is elevated in relation to population with 14.3% of suicides occuring in 8.7% of the population. In the 'Fifty' age group the proportion of inmate population and suicide rate are again almost identical.

In light of Dr. P. Termanson's comments on the pronounced increase in both relative and absolute numbers of suiciders among Canada's youngest age groups, (most notably among 10 to 19 year old males) it is interesting to see that our suicide rate among the 'under 20' age group (consisting of 18% inmate population) is slightly lower, at 11.4%.

Finally, of interest in considering the age factor, is a comparison with other jurisdictions. The results of the recent studies are Corrections Service Canada and the American N.C.I.A. studies are compared with our data.(Table 3)

Table 3

Incidence Of Suicide In Relation to Age
Comparison Of Three Studies

B.C. Corrections 1970-80			C.S.C. (Fed-Canada) 1974-80			N.C.I.A. (USA) 1979		
Age	No.	%	Age	No.	%	Age	No.	%
Under 20	4	11%	Under 20	2	4%	Under 17	15	5%
20-29	16	46%	20-29	23	50%	18-22	96	29%
30-39	8	23%	30-39	12	26%	23-27	85	25%
40 over	7	20%	40 over	9	19%	28-32	55	16%
Total	35	100%	Total	46	100%	33-37	35	10%
						38-42	23	7%
						43-47	9	3%
Mean Age 29.9 years			Mean Age Unknown			48-53	9	3%
						54 over	8	2%
						Total	335	100%
						Mean Age 28 Years		

(For data see Appendix B, C.S.C. Study pp. 52, and N.C.I.A. Study pp. 21.)

While the American study does not easily lend itself to comparison of data because of the differences in portrayal of age groups, our data can roughly compare with the Federal study. Appraisal shows a fairly even comparison of percentages of suicides, the only significant difference being in the 'Under 20' category where suicides in the Penitentiary system were 4% compared with our 11%. It would appear that this would likely be due to the much smaller proportion of younger inmates in the Federal system.

The early 'twenties' appear across the board to show the heaviest suicide rates (literature and current studies confirm); however, while this is an important statistic, our B.C. analysis shows that at least in this jurisdiction, the heavier incidence is not that far out of line with proportion of inmate population. Had the data been available in the Federal and the American studies it might have shown this close link between rates of suicide by age with proportion of inmate population in those age groups.

CONCLUSION:

The age of an inmate does not provide any significant indicator of suicide risk.

It appears safe to say that suicides not only occur in all age groups in B.C.'s inmate community, but from our findings, the rate of occurance roughly approximates the proportion of inmates found in those age groups in relation to the total inmate population.

* * *

Seventeen year old Clyde was found hanging in cell #25 of the "Adjustment Unit" at Haney Correctional Institution on March 18, 1972, at 1805 after the evening meal.

Very little background information is available on this young native from the Kamloops area. Apparently, when he was quite young, his mother died which resulted in his placement in a number of foster homes. Absconding from Kamloops in 1970, he was later apprehended in behalf of the superintendant of Child Welfare in Nanaimo and placed in the Brannon Lake training facility.

After a series of break, enters and thefts in the Nanaimo area, he was admitted to Haney on a 3 month definite, two years less a day indefinite term which commenced April 28, 1971. At the time of his death he had served over half his term, a good deal of which was spent in the adjustment unit for "underachieving inmates who were not successful in program".

Clyde was described as non-communicative, uncooperative and seemingly very bitter.

Having attempted escape by climbing fences three days before his suicide, he was segregated where he slashed his arm with a sharpened toothbrush and the following day opened the wounds with a razor blade. (Both suicide attempts were considered serious) Assuring staff that he would act more responsibly in a rare attempt at communication, Clyde was allowed to return to his unit where he was later successful in his suicide bid.

It is interesting to note that Clyde refused to speak during a psychological interview and cut himself off from both staff and other trainees including other native trainees. He most often refused to talk to anyone and generally spent his time laying face down on his bunk. It was noted at the Coroner's Inquest that staff tried to open communication, e.g., Officer: "Why don't you talk to me, you can't hate me, you don't know me?" Clyde: "I hate everybody".

Apparently this was the first successful suicide in 15 years at Haney, an institution which had handled successfully a great many previous attempts and very disturbed young offenders.

The Coroner's inquest found fault with the institution for not transferring this inmate to an outside mental institution after his two previous suicide attempts. The Coroner's Jury also noted that Clyde should not have been left to the discretion of unqualified personnel and called on the Branch to provide a full time psychiatrist for referral of similar cases.

Key Warnings - Factors for Consideration

1. A very young, noncommunicative inmate with little or no community resources.

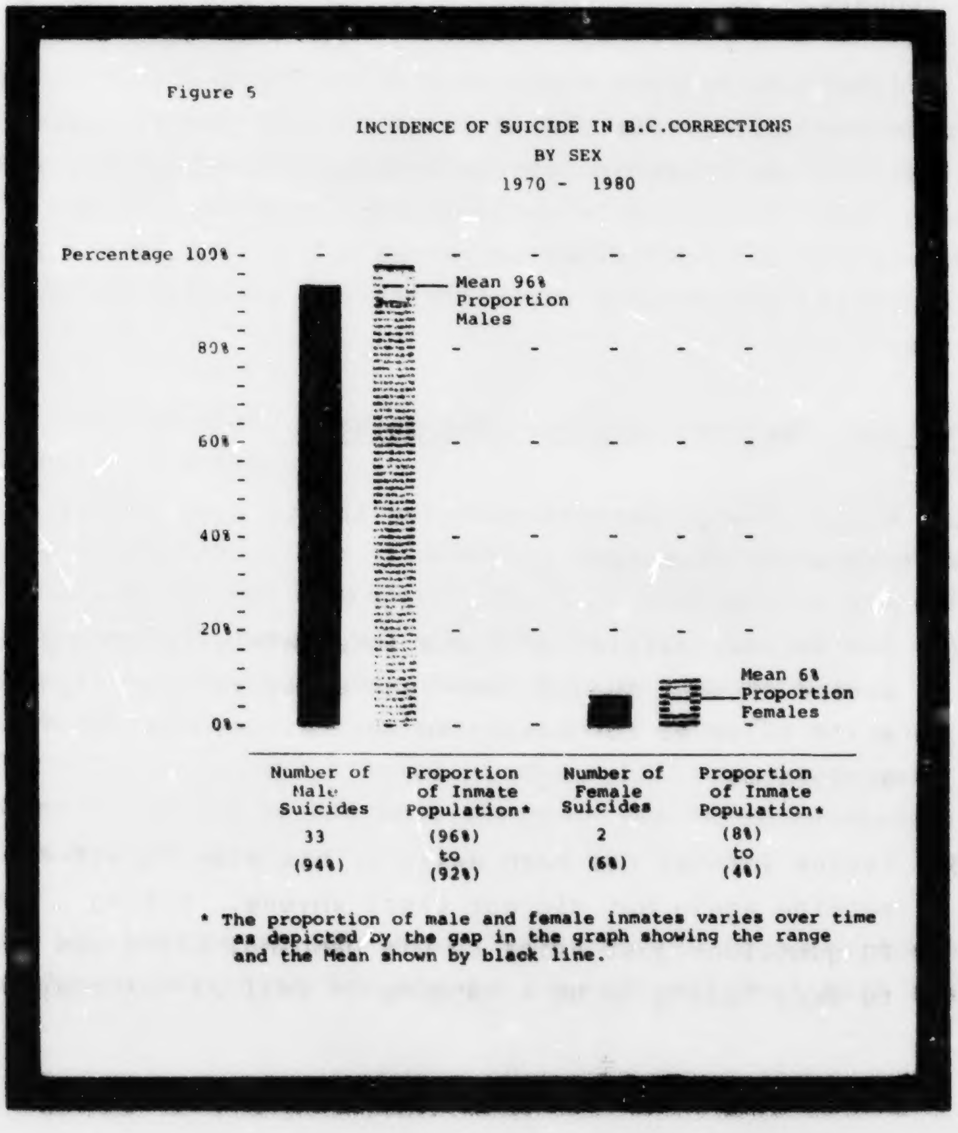
2. Two serious suicide gestures immediately following an escape attempt should have been a key warning sign for staff to refer for qualified medical/psychiatric assistance.

3. Fellow inmates had been aware of his plan to attempt suicide again but did not alert anyone. During a game of 20 questions just prior to his hanging, Clyde was heard to say, "going to be a hanging in cell 25 Saturday night".

INCIDENCE OF SUICIDE IN RELATION TO SEX

In British Columbia's Correctional Institutions females account for approximately 6% of overall inmate population (fluctuating between 4% and 8%). It is perhaps not surprising that the incidents of female suicide in our ten year study also represent 6% of our total suicides.(Figure 5)

Figure 5



Again, it is important to try to compare our data with other jurisdictions and in this regard the American Study appears to make an easy comparison. (Table 4)

Table 4

Incidence Of Suicides In Relation To Sex
Comparison Of Three Studies

	B.C. Corrections 1970-80		N.C.I.A. (USA) 1979		C.S.C.(Fed-Canada) 1974-80	
	No.	%	No.	%	No.	%
Males	33	94%	332	96.5%	46	100%
Females	2	6%	12	3.5%	Nil	0
Total	35	100%	344	100%	46	100%

It would appear, in comparing our findings with the 1979 American research, that our rate of male-female suicide is roughly the same given the size of our sample and the differences between the two studies. It is interesting to note that in the period studied by Correction Service Canada it appears there were no female suicides or they were not factored out.

Perhaps the Federal statistics on "Self-Inflicted Injury" in relation to sex is more indicative of the actual state of affairs, showing roughly the same percentage of incidents in relation to inmate population. Justice Information Report 1978-80 shows the number of females in Federal Penitentiaries to be several percentage points lower than in B.C.'s institutions.

(4) Self-Inflicted Injury Counts By Location Within Institution Canada Total

Sex

	General Cell		Segregation		Other	
	No.	%	No.	%	No.	%
Male	123	97.5	90	95.7	10	100
Female	3	2.4	4	4.3	0	0
Total	126	100	94	100	10	100

Given the facts that female inmates comprise a smaller percentage of the inmate population in Federal Institutions and that the rate of self-inflicted injury reflects the proportion of females in those institutions as in our institutions, we arrive at the question of significance.

In summary, there does not appear to be a significant difference in the incidence of suicide based on sex. The incidence of suicide in our study and that of the Americans roughly reflects the same rate for both male and female inmates.

CONCLUSIONS:

The incidence of female suicide in our Correctional Centres appears closely related to their proportion of total inmate population and thus sex cannot be considered a significant factor in predicting suicidal behaviour or assessing suicidal risk.

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(4) Correctional Service Canada, "Self Inflicted Injuries and Suicides"., Report Prepared by Bureau of Management Consulting Ottawa, 1981, Table 2-11, p.21.

Aside from our overall need for careful assessment and special handling of those individuals designaged as presenting a suicidal risk, we have no recommendations for unusual or unique prevention programs based on the sex of an inmate.

* * *

At 1045, September 2, 1975, Louise, a 31 year old married Vancouver woman with a history of heroin addiction and prostitution, was found in her room at Lakeside Centre hanging from her bed frame by a bathrobe sash.

Having served three months on remand, she had just been committed for trial following a preliminary hearing. The offence involving the murder of an acquaintance on 'skid road', occurred the day after she 'walked away' from Riverview Psychiatric Unit where she had been undergoing treatment. Correctional staff who had come to know her over the years as often abusive and combative, this time found her despondent and non-communicative. In fact, 45 minutes before she was discovered hanging, a matron had chatted with her in an effort to raise her spirits.....

The Coroner's Inquest was told that "very little could be done for (Louise) by way of effecting a positive relationship or a meaningful program of rehabilitation." It was said that Louise, "was a 'born loser' with numerous, unsurmountable problems stemming back to her childhood deprivation and misery. In the past, she had made several suicidal gestures, scaring her wrists and throat superficially." The ultimate gesture they felt was "simply a matter of time and mood"......

Key Warning Signs and Factors for Consideration:

1. Change of affect (abusive-combative to despondent-noncommunicative).

2. Previous suicide attempts.

3. Psychiatric Report "gradual deterioration of mental state ...depressed..constant visual illusory experiences ...feeling tone of baseless fear".

4. Fragile health (epileptic, heroin addiction, psychiatric problems).

5. Trouble sleeping.

6. Significant set-back (committed for Trial after preliminary).

INCIDENCE OF SUICIDE BY BIRTHPLACE

While we do not have all the material available to do an analysis on the social histories of these victims or to factor out many details on their backgrounds, we were able to gather some background data and explore for possible significance.

Keeping in mind that there has been a heavy migration to B.C. from elsewhere in Canada and to a lesser extent from outside our Country in recent decades (Appendix C), it is interesting to note that a majority of our suicide victims were originally from out of Province.(Table 5)

Table 5

Incidence of Suicides in Relation To Place Of Birth

B.C. Corrections 1970 - 1980

Place of Birth		No.	Percentage	Totals
British Columbia	Vancouver	4	11.4%	37.0%
	B.C. Cities	2	5.6%	
	B.C. Rural	7	20.0%	
Other Canadian Provinces	Ontario	5	14.3%	63.0%
	Saskatchewan	4	1.4%	
	Alberta	3	8.6%	
	Quebec	3	8.6%	
United Kingdom	England	1	2.9%	
	Wales	1	2.9%	
United States	Indianna	1	2.9%	
	New York	1	2.9%	
Middle East	Cairo	1	2.9%	
Total		35	100%	100%

Without birthplace data on the general inmate population over this same period of time or comparing with a control group, we are unable to conduct a scientific analysis. However, being cautious in drawing conclusions we are still able to state the fact that 63% of the suicide victims were initially from out of Province and an additional 20% from rural B.C. communities.

One observation may be tendered, that we are perhaps viewing a secondary or derivative factor which may or may not have contributed to the original criminal behaviour or in fact the suicide itself. Cultural dislocation, culture conflict and adjustment problems for rural people coping with an urban environment were likely primary or contributing causes for some of our victims.

Several of our victims were in a transient state immediately prior to their arrest and had few apparent social or familial ties. While we lack data on this factor for a number of the cases in our ten year study, this would seem like a factor for greater focus in future studies and in the inquiries that follow deaths in our institutions. 'Transient state' is closely related to other deficiencies in social environment, i.e. lack of community resources and family contact. These individuals more often than not do not 'make bail' and without local knowledge or support, often show more stress and have greater psychiatric problems according to line and professional staff.

CONCLUSION:

We cannot draw any inferences from our data relative to Place of Birth in relation to the incidence of suicide in our Correctional Centres; however, officers could be alerted to the significance of geographical and cultural dislocation particularly when combined with presence of other destructive factors.

The transient individual on remand with no local support is psychologically vulnerable particularly if he faces serious charges and has few resources. This may be an alert for staff.

* * *

Forty-three year old native Indian, Crawford from rural Saskatchewan, left his wife and family and came to B.C. in 1975 to apparently look for work in his trade, welding. Crawford had a very minor police record but his problem with alcohol became more pronounced after his arrival in Vancouver and dislocation from family resources.

Four years later, and five days after arrest, he was discovered hanging in his remand cell at LMRCC. Crawford faced only a minor term for escape while serving an earlier sentence for driving while disqualified.. Understandably, staff at LMRCC were surprised by his suicide as there were reportedly few if any behavioural indicators.

Listed as "A 1" on admission medical check, police investigators later found his brother-in-law in Vancouver who told them that Crawford had been acting strangely after drinking bouts recently.

Pacing, talking to himself and expressing fear over being killed by a fictitious native named "Bill", Crawford had talked of suicide on several occasions.

Taken by the Detox Unit in Vancouver several times, Crawford did not stay dry long and continued living an aimless, and increasingly fearful life due to alcohol hallucinations.

While these factors were known to his only family contact, who had recently arrived in the city, they were not picked up on when Crawford was admitted. Unfortunately his brother-in-law did not know Crawford was at LMRCC, surmising that he had merely disappeared again.

Key Factors For Warning/Consideration

1. No family or local contacts listed on admission. Indications of dislocation from significant family and friends.

2. Indications of advance alcohol problems, physical signs of Dilerium tremons(D.T.'s), or withdrawal...shakes.

3. Verbalization regarding suicide; any comments made by family or outsiders regarding suicide potential.

4. Poor adjustment, difficulty sleeping, pacing, signs of fear indications of hallucinations.

INCIDENCE OF SUICIDE BY NATIONALITY:

While one would be surprised to see more than a handful of other nationals in our correctional institutions, we see from the following table that 8.5% of our suicides were foreign nationals (See Table 6)

Table 6

Incidence Of Suicide By Nationality
B.C. Corrections 1970-80

		Number	Percentage
Canadian			
	Born in Canada	28	80.0%
	Naturalized or Landed Immigrant	4	11.5%
Foreign Nationals (facing deportation)			
	American	2	5.7%
	Other (Egyptian)	1	2.8%
Total Suicides		35	100.%

In order to evaluate whether in fact the "Foreign Nationals" in the B.C. Correctional System are in greater or lesser jeopardy from a suicide standpoint, we must look at the proportion of this group in our inmate population.

By far the greatest majority of the Foreign Nationals are identified in the Lower Vancouver Mainland Area and to a lesser extent in Victoria because of proximity to the U.S. border and the fact that these cities are ports of entry.

Numbers of cases in this category are somewhat difficult to pin down by virtue of the fact that all foreign nationals are not identified during the admission process. Fictitious names, birth dates and birth places are often given and verification checks, when made, do not always determine the veracity of this information.

We were able to gather, from LMRCC, where the greatest majority of Non-Canadians are identified and held; that over the past 5 years they have averaged 210 "Immigration-Hold" cases per year. For LMRCC this appears to represent between 3 percent and 7 percent of total remand and sentenced admissions. Branchwide, these figures are extrapolated to yield the rough estimate that approximately 1 percent to 3 percent of our total population are foreign nationals who may be held for immigration consideration. Of these, the seriousness varies from those held in temporary detention pending inquiries, those held facing deportation hearing, those awaiting release for voluntary departure and those awaiting deportation.

Line staff and professionals at LMRCC have long recognized the much higher psychiatric profiles, anxiety and stress reactions among immigration detainees. Generally speaking, the "Flags go up" when a case is designated "Immigration Hold", in an institution such as LMRCC; however, it is doubtful that this is general knowledge throughout the system. Therefore the recognition of this factor may be a useful suicide prevention training aid.

The opening of the new Vancouver Pretrial Services Centre in Vancouver, naturally shifts the location of the immigration detention cases from LMRCC to the new facility, and as a result, it would seem important to focus attention on staff training in the area of suicide prevention, with attention given to the particular problems of immigration cases.

In reviewing the B.C. Corrections data on "Foreign National" suicide cases, it was found that all were awaiting deportation or in the throws of fighting battles with Canadian Immigration authorities over the issue of deportation. While circumstances differed, two of our victims faced serious charges in their home countries with one extremely concerned over severing social/vocational ties in this country. One was a reclusive sort whose motivation for suicide was by no means clear.

CONCLUSIONS:

Despite the apparent limited numbers of foreign nationals in our institutions and the difficulty of identifying those individuals, the proportion of suicides in this group suggests that those on immigration detention are somewhat more vulnerable to suicide than the general inmate population.

Depending on the seriousness of the charges awaiting a foreign national facing deportation and/or depending on his feelings of anxiety concerning the severing of current Canadian ties or disruption of life, we may have a potential suicide candidate.

The key would appear to be exercising care in assessing all individuals on "Immigration Hold" or facing immediate deportation.

Where suicide potential is identified, Correctional Staff should advise and liaise closely with the Courts and lawyers to be aware of significant developments.

* * *

On December 17, 1980, a 32 year old foreign national, facing deportation, was found dead in his South Wing LMRCC Observation cell at 0340 in the morning. It was discovered that he had overdosed on prescription medication hoarded over a period of time. Last checked alive at 0130 in the morning, staff merely thought Ab was sleeping, (snoring on earlier checks).

Ab who had previously been granted permanent residence in Canada by virtue of his marriage to a Canadian, was now facing imminent deportation as a result of a series of violent crimes. His lawyer had called him earlier the day before to advise him that appeals against deportation had failed. However, staff were unaware of this development and the letter of official notification advising of deportation arrived several hours after his suicide, obviously of no assistance in alerting staff.

Ab's stormy career of violence in Canada commenced shortly after his marriage to a Canadian woman. Having charges of attempted murder reduced to wounding, following a vicious knife attack on his first wife, Ab received a 7-year sentence and was ordered deported. Refusing parole because of the deportation order, he was eventually released in 1978 on mandatory supervision, but was held for a year at LMRCC for immigration consideration. Eventually the deportation order was stayed to allow him an opportunity to prove himself. Less than a year later he was again arrested for assault causing bodily harm, the victim being his current fiance. The deportation order was again activated and his appeals against this order failed the day before his suicide.

L.M.R.C.C. staff reported that Ab was a well-adjusted prisoner appearing to get on well, "easy going - an excellent cleaner". A positive psychiatric report, though dated, dovetailed with his positive institutional adjustment. There had been no previous threats of suicide or any indications of violence in his adaptation to jail.

Apparently there were no suicidal indications to staff members; however, he had previously told a fellow-inmate about his fear of deportation and that "he would be dead before they got him out of that cell". He reportedly had desserted his country's army and faced serious consequences if returned. Unfortunately, as mentioned, his lawyer advised him of his pending fate by phone, the official notification arriving too late to be of value.

It was later determined that over the course of several months, Ab had managed to hoard a potentially lethal supply of prescription pain killers and sleeping medication through regular visits to the doctor with complaints of backpains.

Key Warnings - Factors For Consideration

1. The potential for acquiring and hoarding medication was highlighted by this case.

2. The realization that apparent good spirits and favorable adjustment can often mask a potentially suicidal inmate.

3. The ramifications on an inmate's deportation need to be carefully assessed.

Action Taken

As a result of this particular suicide, a total enquiry into health care services, in particular, the distribution, handling and control of medication was sought from the medical and pharmacological communities.

INCIDENCE OF SUICIDE BY RACE/ETHNIC BACKGROUND:

At risk of getting into the trap of "comparing apples and oranges" this data is presented in hopes of identifying possible major cultural differences in suicide proneness in our Correctional Institutions. Unfortunately, the Federal Corrections Service did not examine this variable and accordingly, our only comparison is with the American study of 1979. The N.C.I.A., of necessity, included a large black population which in reality, does not yield a valuable comparison for the British Columbia data.(Table 7)

Table 7

Comparison of Suicides in Relation to Ethnic Origin/Race

B.C. Corrections 1970-1980	No.	%	N.C.I.A.(USA) 1979	No.	%
Caucasian	28	80%	White	231	67%
Native Indian	6	17%	Black	74	22%
Other(Egyptian)	1	3%	Other*	38	11%
	35	100%		344	100%

*Other includes American Indian, Spanish/Mexican and unspecified

We must consider the percentage of Native Inmate Population in relation to suicide.

We do know that on March 31, 1980, 9% of the inmates in the custody of the Federal Corrections Service were Native Canadian, Metis or Eskimo, which we understand is representative of the average proportion of Native peoples in Canadian Penitentiaries.(5) Unfortunately, we do not know what percentage of Federal inmate suicides were Native Canadians.

In British Columbia's Provincial Correctional Centres, however, there is a significantly greater proportion of Native peoples in the inmate population. B.C. statistics in the early 70's reflected percentages in the mid-teens for native admissions; however, it would definitely appear that the proportion has risen and will likely remain between 17% and 19% given the forecast in "Prespectives Canada III".(6)

Given the fact that native peoples now approach 2.5% of the total Canadian population (600,000 of 24,000,000) we would expect a much lower proportion of Natives in our prison populations, certainly 17 - 19% is highly disproportionate.

In terms of suicide within our Branch, however, the numbers in our ten year study reflects almost the exact ratio (17%), which at least suggests that suicides in our system to date do not appear to have a preponderance of native victims far in excess of their proportion in the inmate populations.

CONCLUSIONS:

Clearly, the factors of the race and ethnic background of our suicide victims are of little value in providing an indicator of suicide potential.

It appears from our B.C. Corrections data, that as far as native offenders are concerned, there are not a disproportionate number of their group suiciding in our institutions.

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(5) Justice Canada, "Correctional Services In Canada", 1978/79, 1979/80, Report by Work Group Justice Information and Statistics, Ottawa, 1981.

(6) Statistics Canada, "Perspectives Canada III", Ottawa 1981, p. 174.

* * *

Seventeen year old Paul from the remote north coast native community of Bella Bella, B.C., was found at 0055 on a Saturday morning in September 1978, hanging from the bars above his cell door in the remand tier at LMRCC.

Awaiting trial with his co-accused for the beating death of an elderly Chinese shopkeeper, Paul had been held for three months, ten days on this his first admission to LMRCC. He had several earlier scrapes with the law at Bella Bella, with both juvenile and adult probation, as well as one short jail term for theft of a car recorded on his case history.

Paul had a series of set backs, the cumulative total seeming to be the key to his eventual demise:

1. His co-accused had not made a statement clearing Paul, as Paul had expected,
2. The recent loss of his grandfather, a key person in his upbringing, was compounded by the fact that he could not attend the funeral at the reserve because of the great distance and the cost of escorts, etc.,
3. Disciplinary action for possession of contraband ($1.40) saw his first visit with his common-law wife cancelled,
4. The cancelled visit had been important, as this would be his first opportunity to "pack" his newborn baby, a native custom.

In his suicide letter to his common-law wife, Paul maintained his innocence and portrayed his distrust for the judicial system.

It was noted that one Correctional Officer had been doing an outstanding job of trying to assist Paul while the Chaplain was trying to set up visits for his wife and baby.

Paul was found forty minutes from the last visual check at 0015, Correctional Officers had difficulty cutting Paul down but must have happened on the scene shortly after his suicide attempt. He lived for 8 days in a Vancouver Hospital before his death, underlining the possibility that his life might have been saved had he been found just a little earlier and First Aid initiated sooner.

Key Factors for Consideration/Warning:

1. Rather noncommunicative native Canadian, with few resources,

2. Few if any visitors, family located on remote reserve,

3. The unforeseen effects of a minor disciplinary action (cancellation of key visit),

4. The Correctional Officer supporting him took normal shift leave only to find his charge had suicided on return. The question of backup is raised.

5. The matter of immediate capability of cutting a hanging prisoner down and the capability of all guards in providing trained First Aid (two minutes without air causes permanent brain damage.)

INCIDENCE OF SUICIDE BY MARITAL STATUS:

Another interesting factor in our study of suicide is the relationship of Marital Status, the key, belived to be the presence or absence of the supporting relationship of a spouse.(Table 8)

Table 8 Comparison of Suicides In Relation To Marital Status, B.C. Corrections 1970 - 1980

	No.	%
Single	14	40%
Married	5	14%
Separated	5	14%
Divorced	2	6%
Widowed	2	6%
Common-Law	7	20%
	35	100%

At first consideration, one sees that the largest group of those that suicide are single, and when taken with those in the separated, widowed and divorced group, constitute 66% of our study sample. Only 34% of our victims were listed as married or living common-law.

Strictly speaking, to determine the significance of this factor, one should look at inmate population and determine what proportions fall into the various categories. Unfortunately, this data is not collated from admission sheets in our Branch; consequently, we will have to deal with this data at face value.

Perhaps it will be of greater value to look at the other jurisdictions to get some indicators. A glance at the Correction Service of Canada federal data reveals a fairly even distribution of suicides in proportion with each marital group in the penitentiary system. Singles make up 55% of federal inmate population, marrieds 15% and perhaps not surprising, the rates of suicide correspond quite closely on this factor.

(7) Comparison of Suicides to Maximum and Medium Security Penitentiary Population With Respect to Marital Status

	Penitentiary Population		Suicides	
	No.	%	No.	%
Single	4285	55	26	56
Married	1169	15	5	11
Separated	348	5	2	4
Common-Law	1313	19	9	20
Divorced	336	4	1	2
Widower	100	1	3	7
Not Stated	20	1	0	0
TOTALS	7771	100	46	100

A comparison amoung the three studies shows rather remarkable similiarities in the percentage distribution of suicides in relation to marital status.(Table 9)

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(7) Reprint from C.S.C. "Self-Inflicted Injuries and Suicides", p. 56.

Table 9

Incidence of Suicides in Relation to Marital Status
Comparison Of Three Studies

	B.C. Corrections 1970-80		N.C.I.A. (USA) 1979		C.S.C. (Fed-Canada) 1974-80	
	No	%	No	%	No	%
Single	14	40	154	54	26	56
Separated	5	14	17	6	2	4
Divorced	2	6	27	9	1	2
Widowed	2	6	3	1	3	7
Married	5	14	82	28	5	11
Common-Law	7	20	5	2	9	20
TOTALS	35	100%	288	100%	46	100%

It would appear from the three studies that almost 70% of the suicide victims were single, separated, divorced or widowed, while just over 30% were married or listed as living common-law. This data would suggest that single, separated,divorced or widowed prisoners on this index alone have a two-thirds greater risk of suicide than married prisoners (common-law included).

Certainly the key issue is not the mere designation of marital status but the quality of the interpersonal relationships behind these labels. As we will see in later discussion, under the heading Precipitating Factors, negative relationships in a marriage, or common-law arrangement can in fact be a crucial factor in an inmates decision to commit suicide.

CONCLUSIONS

While marital status alone is by no means a factor which indicates potential for suicide, it can be indicative of important community relationship support or lack thereof.

* * *

Forty-five year old John was found hanging in his LMRCC cell 12 minutes after he was last checked following a lunch break in May 1972. John had served 5 days on remand for possession of stolen property and failing to attend Court.

No stranger to LMRCC, John's record dated back to 1944 when he came out of the Armed Services and consisted mainly of false pretence and drug related offences.

Angry with his wife for not "bailing him out", he warned her during a visit several days earlier, that he would suicide if she didn't get him out. As she testified at the Coroner's Inquest, his involvement with drugs and the deterioration of their family relationship which resulted was a key in her decision to not 'go bail' this time. (He had apparently introduced their 16 year old son to drugs a well). According to John's wife, she did not take his suicide threat seriously and felt there would be no way he could accomplish his own death in custody in any case.

Disciplined on the day of his suicide for having contraband money ($20.00), officers found a noose when they searched his cell, consequently, he was moved to a front cell "for better observation."

John took his medication at noon but did not have his lunch. An officer, noting this, asked, "Are you O.K?" and was given a shrug of the shoulders.

Key Factors for Consideration:

1. Important conflict with his wife.
2. Wife heard the threat but didn't report it as she did not take it seriously.
3. Series of setbacks, no bail, mild withdrawal, letter from wife noted financial problems, discipline action the same day and conflict with wife.
4. Finding the noose in his cell earlier, staff went on partial alert by moving him to an area of greater visibility.

In offsetting the warning signs, it might be said that there are other factors which did not indicate a potential suicide risk. John was an old hand at jail, knew his way around and was not facing serious charges or a long term that staff were aware of.

INCIDENCE OF SUICIDE BY INTELLIGENCE

Unfortunately we were unable to gather sufficient data to allow an examination of the factor of intelligence in the cases of suicide in the Corrections Branch. The American Study was similarly restricted; however, the Federal Study did examine this factor for both suicide victims and self-inflictors. The non-conclusive results are given as follows from the Corrections Service Canada Report:
(8)

(8)

Table 3-13 displays a comparison between inmates who commit suicide and non-fatal self-inflictors on the basis of intelligence. It is quite clear that the two groups are not distinguishable on the basis of this variable. Reliable figures are not available for the inmate population as a whole. It does appear that, for non-fatal self-inflictors and inmates who commit suicide, the distribution of I.Q. is similar to that for the inmate population as a whole. There are slightly more inmates in the two groups that are below average than above, but the numbers are so small that the difference could be the result of random variation. Even if it is not, it might just mirror the fact that the inmate population contains slightly more inmates classified as having a below average I.Q. than inmates classified as having an above average I.Q.

Table 3-13

Comparison of Suicides to Non-Fatal Self-Inflictors with Respect to I.Q.

	Non-Fatal Self-Inflictors		Suicides	
	No.	%	No.	%
Above Average	12	8	5	11
Average	121	77	31	67
Below Average	23	14	7	15
Don't Know	2	1	3	7
TOTAL	158	100	46	100

Ignoring Don't Know category gives:

Chi Square = 0.79 d.f. = 2 Not Significant

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(8)Reprint from C.S.C.," Self- Inflicted Injuries and Suicides," p. 57.

An examination of the literature, particularly the well-researched annotated bibliographies in the Federal Corrections Report, shows that time spent sifting our inmate population statistics and more specifically our victims histories for I.Q. scores would be time more productively spent elsewhere.

CONCLUSION:

It appears clear that we are unable to use the factor of intelligence to assist in predicting suicidal behaviour in B.C. Corrections even if reliable I.Q. scores were available at the time of admission.

* * *

Tall, good-looking, 18 year old Robert had spent five weeks on remand and was about 10 days away from Trial on attempted robbery and for theft of his girlfriend's car, when he was found hanging in his West Wing LMRCC cell at 0219 on a Friday morning in April of 1978.

Originally very little background information was held on Robert; however, it was recently learned that he had been a ward of the Superintendant of Child Welfare for years following his parent's separation and his mother's suicide when he was 10 years of age. Foster parents reported that Robert had been "a basically nice young fellow" who seemed unable to keep friends for any length of time. He had a mercurial personality with periodic outbursts of temper. An average student at school, he, nevertheless, was tested as being brighter than his marks indicated.

Profoundly influenced by his mother's suicide and his disrupted home background, one gets the impression these were some of the key factors in his vulnerability. Leaving his final foster home and returning to his father's, he was unemployed for some time until joining the Armed Forces where he became involved in difficulties selling soft drugs. After going AWOL he was discharged and ran further afoul of the law in an attempted armed robbery late in 1977. Absconding to the U.S. with his girlfriend's car prior to trial, he was apprehended in California and deported to Canada where he awaited Court in LMRCC.

Institutional records showed he was a cooperative, unobtrusive inmate who was not reported as having any psychological or medical problems. Similarly, there were few, if any, behavioural indicators. It is only when reviewing his suicide letters that a picture of frustration and depression is uncovered. His family apparently knew of previous suicide attempts; however, the only indication that may have alerted Corrections Branch staff was old scars on one wrist.

Key Factors For Consideration/Warning

1. The importance of a previous family suicide. This can in itself be a warning sign.

2. The disrupted background, internal turmoil and loss of self-esteem did not seem detectable until we read the suicide notes.

3. Perhaps the only visible clue was the evidence of earlier slashing attempts found in scars on one wrist.

INCIDENCE OF SUICIDE BY RELIGIOUS AFFILIATION

The factor of religious affiliation was examined by noting admission sheet informaion as well as obtaining confirmation through other sources where possible. Recognizing the very real pitfall in taking this information from Inmate admission sheets which were initially recorded from inmate verbal reports, we are aware of the question of reliability of this information and are hesitant to draw conclusions. This caution is particularly emphasized when we realize there are no qualitative measures on strength of religious belief, or degree of affiliation, or practice of one's religion. This data is, however, reported in any case.(See Table 10)

Table 10

Incidence Of Suicide By Religious Affiliation
B.C. Corrections
1970-1980

Denomination	No. of Suicides	Percentage
Protestant	13	37%
Roman Catholic	7	20%
Other (Moslem)	1	3%
No Affiliation	8	23%
Unknown	6	17%
	35	100%

As can be seen, there are no apparent clear indicators even if the measure was highly accurate. For meaningful figures it would also be essential to know the proportion of inmates in each religious group for any comparative purposes.

Other studies referred to did not conduct comparative analysis on the basis of religion.

CONCLUSION:

From data available, there can be no indicators of suicide potential drawn from an examination of an inmate's religious affiliation.

* * *

Gary, a 27-year old male from the prairies, came to B.C. in the late 1970's after his parents separated in Saskatoon. Having three previous admissions to Oakalla in a year and a half, Gary was on this occasion serving a 3 month term for 2 charges of theft.

Admitted on Oct. 9, 1979, he had served half of his sentence and was on his 6th day in segregation at Westgate 'A' when he was found hanging from the ceiling bars of his end cell on an empty tier at 1555. Staff had just finished serving dinner and handing out medication when they discovered him.

Gary, a very aggressive and erratic man, had previous psychological problems but was not classified psychotic or committable. Considered a trouble-maker by both guards and inmates, he had been a persistent adjustment problem since admission.

Apparently, Gary had very strong religious beliefs and was constantly preaching to fellow-inmates. This appeared somewhat unusual given his F.P.S. record for property offences and his abusive behaviour toward staff. (Regularly shouting obscenities at staff and throwing his bucket on officers).

Gary had previously written to Inspection & Standards claiming concern over sexual aberation in prison, homosexual activity with claims that guards overlooked these incidents and threatened inmates with homosexual attacks. He also believed he was being harassed by inmates and staff for his religious beliefs. While his complaints were unsubstantiated, it was clear from his letter that he was a lonely individual, feeling vulnerable, isolated and harrassed. The inconsistent nature of his complaint vis-a-vis his very abusive behaviour, made his motivation difficult to understand.

Gary had been interviewed over his adjustment problems and anger with staff in segregation by the medical director of LMRCC, a man with years of psychiatric training, just hours before the suicide. The medical director noted his anger was not turned inward at self but was directed at staff. Gary was not found to be psychotic or committable.

A very strange suicide note was left:

> "IN THIS IS
> TRUE LOVE THAT
> A MAN LAY
> DOWN HIS LIFE
> FOR HIS BRETHREN"

Key Warnings and Factors for Consideration:

1. Isolation within isolation (end of tier and only man on that tier).

2. Confused thinking bordering on referral to mental hospital. The difference between psychotic and severe depression is difficult to guage even for professionals.

3. Abusive inmates are particularly hard to handle in our system and its difficult for staff to remain sensitive and interested in their problems.

INCIDENCE OF SUICIDE BY TYPE OF OFFENCE

In examining the incidence of suicide in relation to the Type of Offence, vis-a-vis violence against person as opposed to an offence against property, we see the following distribution of our victims' charges/offences (Table 11)

Table 11

SUICIDE VICTIMS CURRENT OFFENCE OR CHARGE

B. C. CORRECTIONS 1970-1980

Property Offence		Violent Offence	
Type	No. of Suicides	Type	No. Of Suicides
Alcohol Related	4	Murder	8
Drug and Property	4	Violence	7
Property	6	Violence (and Property)	3
Property (and Violence)	3		
Total	17 (49%)	Total	18 (51%)

By adding alcohol and drug related offences, as victimless crimes, to the Property Offence category, we see almost an even division between suicides among property offenders compared with violent offenders.

While we do not have accurate statistics for offence categories for all inmates in the B.C. Corrections system over the ten year period, we are able to extrapolate from current admission statistics to firmly establish that property offenders far outnumber the violent offenders on a consistent basis. Burtch and Erickson also found this to be an axiom in their extensive review of the literature and in their own research. (9)

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(9) Burtch, Brian E. and Erickson, Richard V., "The Silent System: An Inquiry into Prisoners Who Suicide and Annotated Bibliography", University of Toronto, 1979, p.5

As a general proposition most experts would agree that in Canada, Provincial jail systems contain greater proportions of property offenders as opposed to violent offenders than would be found in the federal penitentiary system. Certainly this is the case in B.C. Corrections where current statistics show less than one third of admissions are facing charges involving violence or weapons offences.

Therefore, our study would show that although suicides in the two groups are almost equal, the fact is that the violent suiciders have a higher suicide rate because they are in a definite minority proportion of the inmate population.

If we look at Offence Pattern or Criminal History (making judgement calls in a few cases where both types of offences have occurred), we find, not surprisingly, that property offenders outnumber the violent offenders in a rough ratio of 2 to 1. Thus property offenders have the highest actual number of suicides (Table 12).

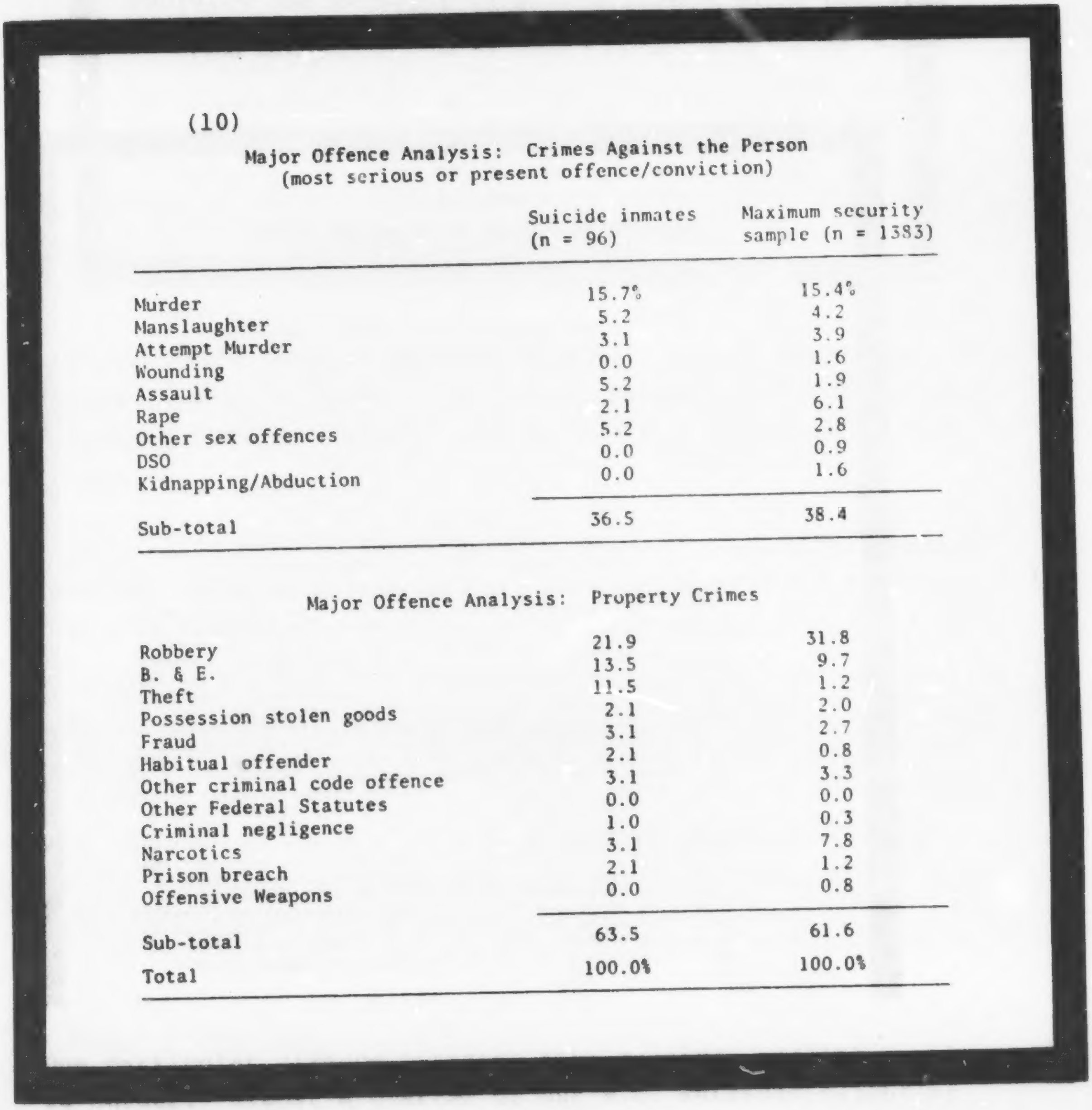
Table 12

Suicide Victims Major Offence Pattern
B.C. Corrections 1970-1980

Property Offence Pattern Type	No. Of Suicides	Violent Offence Pattern Type	No. Of Suicides
Alcohol Related	4*		
Drug and Property	4	Murder	3***
Property	12*	Violence	6
Property (and Violence)	3	Violence (and Property)	3
Total	23 (66%)	Total	12 (34%)

*Denotes a First Offence therefore term "offence pattern" somewhat of a misnomer.

In their own study Burtch and Erickson, using a control group of Canadian Penitentiary inmates, set out to test whether persons convicted for crimes against persons would be over represented in the sample of suicidal inmates, with the subcategory of murderers being the most prone to suicide (10)



(10)

Major Offence Analysis: Crimes Against the Person
(most serious or present offence/conviction)

	Suicide inmates (n = 96)	Maximum security sample (n = 1383)
Murder	15.7%	15.4%
Manslaughter	5.2	4.2
Attempt Murder	3.1	3.9
Wounding	0.0	1.6
Assault	5.2	1.9
Rape	2.1	6.1
Other sex offences	5.2	2.8
DSO	0.0	0.9
Kidnapping/Abduction	0.0	1.6
Sub-total	36.5	38.4

Major Offence Analysis: Property Crimes

Robbery	21.9	31.8
B. & E.	13.5	9.7
Theft	11.5	1.2
Possession stolen goods	2.1	2.0
Fraud	3.1	2.7
Habitual offender	2.1	0.8
Other criminal code offence	3.1	3.3
Other Federal Statutes	0.0	0.0
Criminal negligence	1.0	0.3
Narcotics	3.1	7.8
Prison breach	2.1	1.2
Offensive Weapons	0.0	0.8
Sub-total	63.5	61.6
Total	100.0%	100.0%

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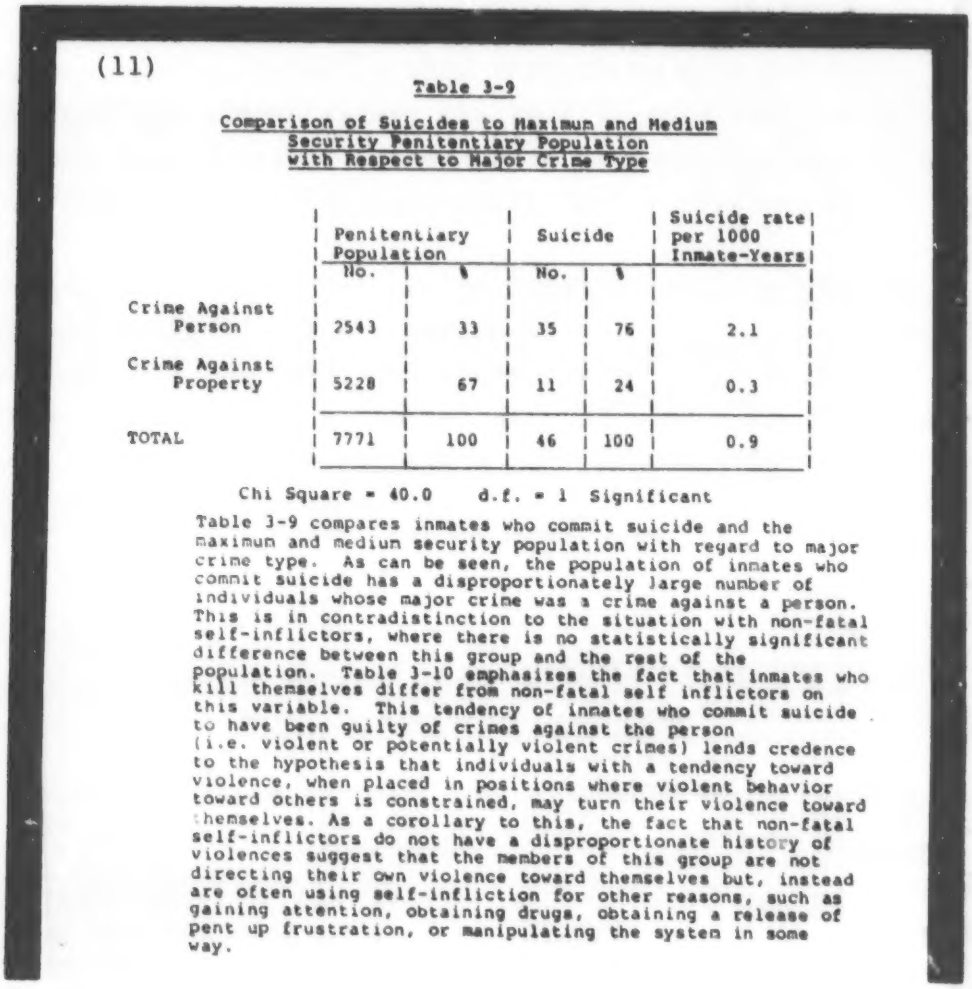
(10) Burtch & Ericson, The Silent System, pp. 52-53. "Our findings seriously question the notion that conviction of violent crimes is firmly linked to suicide of inmates and the supposed link between heteroaggression and autoaggression remains a questionable supposition which holds little promise in the prediction of inmate suicide".

While presenting contrary evidence to some degree it is nevertheless important to examine the latest Federal Study in relation to both self-inflicted injuries and suicides vis-a-vis violence and property offences.(11)



(11)

Table 3-9

Comparison of Suicides to Maximum and Medium Security Penitentiary Population with Respect to Major Crime Type

	Penitentiary Population		Suicide		Suicide rate per 1000 Inmate-Years
	No.	%	No.	%	
Crime Against Person	2543	33	35	76	2.1
Crime Against Property	5228	67	11	24	0.3
TOTAL	7771	100	46	100	0.9

Chi Square = 40.0 d.f. = 1 Significant

Table 3-9 compares inmates who commit suicide and the maximum and medium security population with regard to major crime type. As can be seen, the population of inmates who commit suicide has a disproportionately large number of individuals whose major crime was a crime against a person. This is in contradistinction to the situation with non-fatal self-inflictors, where there is no statistically significant difference between this group and the rest of the population. Table 3-10 emphasizes the fact that inmates who kill themselves differ from non-fatal self inflictors on this variable. This tendency of inmates who commit suicide to have been guilty of crimes against the person (i.e. violent or potentially violent crimes) lends credence to the hypothesis that individuals with a tendency toward violence, when placed in positions where violent behavior toward others is constrained, may turn their violence toward themselves. As a corollary to this, the fact that non-fatal self-inflictors do not have a disproportionate history of violences suggest that the members of this group are not directing their own violence toward themselves but, instead are often using self-infliction for other reasons, such as gaining attention, obtaining drugs, obtaining a release of pent up frustration, or manipulating the system in some way.

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(11) C.S.C Self Inflicted Injuries and Suicide, pp. 54-56.

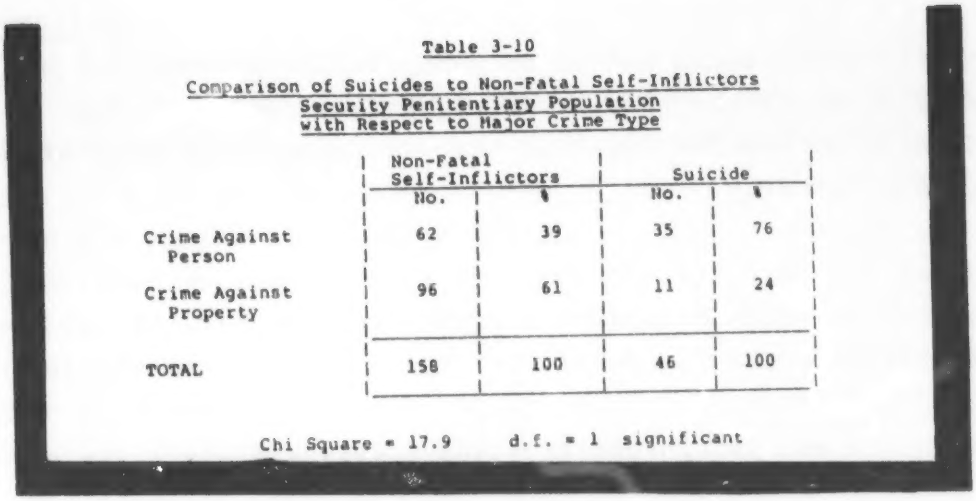

Table 3-10

Comparison of Suicides to Non-Fatal Self-Inflictors
Security Penitentiary Population
with Respect to Major Crime Type

	Non-Fatal Self-Inflictors		Suicide	
	No.	%	No.	%
Crime Against Person	62	39	35	76
Crime Against Property	96	61	11	24
TOTAL	158	100	46	100

Chi Square = 17.9 d.f. = 1 significant

Clearly, the C.S.C. Study shows a significantly close link between higher self-inflicted injury rates for the Property Offenders vis-a-vis higher suicide rates for Violent Offenders.

The American Data on "Most Serious Charge" (12) shows violent personal offences second to "Alcohol and Drug Related" with "Serious Property" and "Minor Other" categories close 3rd and 4th positions respectively.

(12) Most Serious Charge
In Suicide Case

	No. Of Suicides	Percentage
Alcohol/Drug Related	102	30.3%
Serious Property	75	22.2
Minor Other	71	21.1
Violent/Personal	89	26.4
Total	337	100.0%

One particular offence category that deserves special mention is Murder. Almost a quarter of our B.C. suicides (eight of thirty-five) faced murder or manslaughter charges and one additional victim thought he might face execution for desertion from the Egyptian Army on his pending deportation to that country.

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(12) NCIA, Darkness Closes In, p. 23.

Given the very limited scope of this offence category and the relatively high number of suicides represented, it would seem that this group is significant in our suicide statistics.

To quote and paraphrase from the N.C.I.A. Study

> "Despite the NCIA finding that only one qurater of the most serious offenses was violence related, a review of the literature uncovers data relating suicides to offences in which death occurred, particularly murder. This literature suggests that persons charged with various death-related offences, (i.e. 1st degree murder, manslaughter, attempted murder etc.) are more likely to commit sucide than persons charged with other offences.
>
> The Federal Bureau of Prisons has warned local jailers that 'persons held for murder or other offences involving a possible death penalty' should be watched closely for any suicidal tendencies."(13)
>
> \- *** -
>
> "In addition to hypothesizing that an inmate prefers taking his own life rather than suffering through a long period of incarceration and possible execution, theorists also argue that a suicide could be provoked by an inmate feeling particularly remorseful following the killing of a family member or acquaintance.
>
> Although findings from the NCIA study do not support the view that offences of jail suicide victims are 'violence related', evidence from the present study does suggest that the offence of murder can be a significant factor in an inmate's attempt to take his life." (14)

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(13) Ibid, p. 24.
(14) Ibid, p. 24-25.

CONCLUSION:

While type of offence gives no definative indicator vis-a-vis suicide potential, we do see in our B.C. institutions a higher rate of suicide among violent offenders with murderers having a particularly high incidence.

Clearly, if other suicide danger signals are present, the violent offender, particularly the inmate charged with murder or facing a possible life term, deserves special watching from a suicide prevention point of view.

* * *

Early on the morning of Wednesday, May 7th, 1975, Bill, a 22 year old transient from Calgary Alberta, was found hanging by a bedsheet from the electrical outlet in the ceiling of his South Wing L.M.R.C.C. Observation cell. Checked at 20 minutes after midnight in his bunk, he was reportedly found 13 minutes later by staff on rounds. Considered suicidal, Bill had been housed in Special Observation for two of the three and a half months he had been in custody awaiting trial. Bill was assessed by doctors on two occasions as being "more than an average suicide risk" and developing a "paranoid state" during his remand period.

Charged with the sex-slaying of a Port Moody housewife whose husband had befriended him (providing temporary accomodation and work), Bill claimed that he had returned to the victim's home to get back pay owing and under the influence of drugs did not remember the offence. His stories varied; however, he maintained his innocence until his suicide note to his grandparents via his lawyer intimated that he felt remorse for his actions:

> "I'm sorry for what I did, and I know that I deserve the life sentence; but I figure that if I kill someone then I deserve to die. Dying does not scare me and it brings no sorrow I had to do it this way because this way I know when and why."

The product of a disrupted home, Bill had been in and out of trouble as a juvenile and as an adult with a pattern of property offences associated, to some extent, with supplying a drug habit. With three previous psychiatric hospitalizations, despite his tall, capable appearance, he was experiencing fear, anger and frustration. In well documented "progress logs", Correctional staff had described his demanding and abusive behaviour as well as their concerns for his safety.

The offence and its sordid detail had been sensationalized to some degree by the press. Evidence was presented to the Coroner's Inquest that Bill had told other cell mates that he would never go to the penitentiary:

> "If I go to the pen my life won't be worth a plugged nickel."

While the suicide attempt using the electrical outlet in the centre of the cell, out of sight of the officers station, failed to be anticipated; the short time between last check and discovery seemed to indicate staff must have been very close to catching this one in time.

Key Factors For Consideration/Warning:

1. Facing murder charge (widely publicized sensational case) justifiable concern for inmate vindictiveness.

2. Fear of penitentiary.

3. History of psychiatric hospitalization and current assessment of suicidal risk.

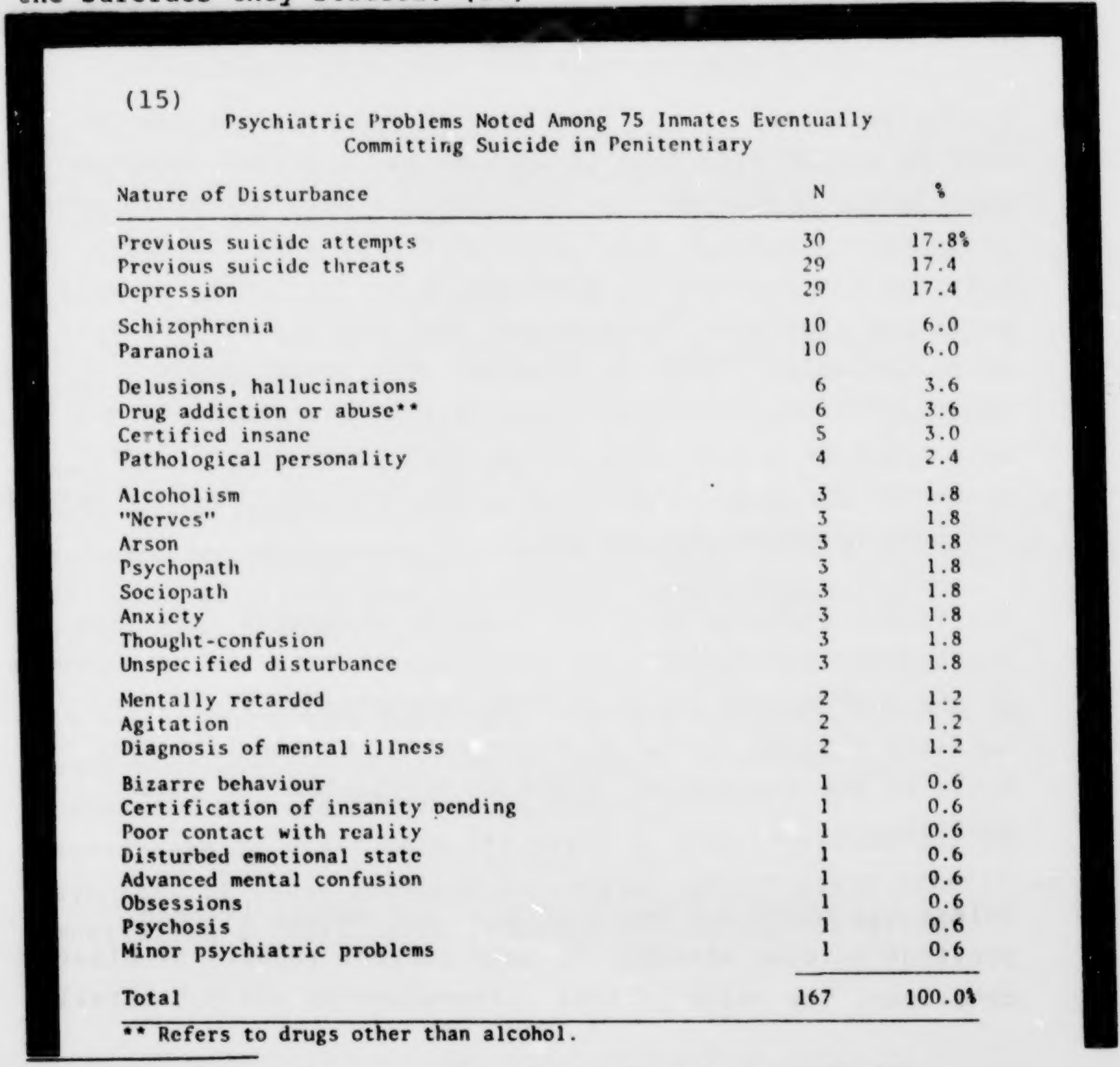
4. Despite knowledge of suicidal intentions and precautionary measures, some suicide scenarios are extremely hard to anticipate.

PART IV

PSYCHIATRIC FACTORS

INCIDENCE OF SUICIDE BY PREVIOUS PSYCHIATRIC HISTORY

It is generally true that a history of mental illness increases the liklihood, or risk, of suicidal behaviour. Burtch and Ericson, in their study of Canadian Penitentiary suicides noted that 30% of the 96 inmate suicides they studied had evidenced histories of 'depression' prior to their deaths. They also showed the fact that 'previous threats' and 'previous attempts' together with 'depression' topped the list of psychiatric problems most often found in the suicides they studied. (15)



(15)

Psychiatric Problems Noted Among 75 Inmates Eventually Committing Suicide in Penitentiary

Nature of Disturbance	N	%
Previous suicide attempts	30	17.8%
Previous suicide threats	29	17.4
Depression	29	17.4
Schizophrenia	10	6.0
Paranoia	10	6.0
Delusions, hallucinations	6	3.6
Drug addiction or abuse**	6	3.6
Certified insane	5	3.0
Pathological personality	4	2.4
Alcoholism	3	1.8
"Nerves"	3	1.8
Arson	3	1.8
Psychopath	3	1.8
Sociopath	3	1.8
Anxiety	3	1.8
Thought-confusion	3	1.8
Unspecified disturbance	3	1.8
Mentally retarded	2	1.2
Agitation	2	1.2
Diagnosis of mental illness	2	1.2
Bizarre behaviour	1	0.6
Certification of insanity pending	1	0.6
Poor contact with reality	1	0.6
Disturbed emotional state	1	0.6
Advanced mental confusion	1	0.6
Obsessions	1	0.6
Psychosis	1	0.6
Minor psychiatric problems	1	0.6
Total	167	100.0%

** Refers to drugs other than alcohol.

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(15) Burtch & Ericson, The Silent System, pp. 56-60.

* Thus, twenty-one inmates had not been depicted as in need of psychiatric or clinical treatment. Considering the questionable validity and reliability of psychiatric diagnoses, in some cases we may argue that psychiatric difficulties are imputed to inmates by clinical staff; in other cases, it is unquestionable that symptoms of depression and, of course, of actual suicide attempts, reflect real difficulties experienced by the inmate. Since we have relied upon public documents, we do not attempt to discredit these diagnoses nor to accept them uncritically at face value. The tentative results, however, suggest that many inmates who do suicide have been recognized as distressed by officials.

In review of the 35 suicide cases in B.C. Corrections ten year study, we find that 13 victims had previous reported psychiatric histories. An additional 4 were presently under psychiatric care. A total of 9 of the 17 were currently referred for psychiatric assessments by the Court, or were receiving treatment for problems that had come to the fore since admission. When we consider that these totals represent 'identified' previous psychiatric cases, we may be sure there is a high probability that there is a 'hidden' component among our victims who were not identified as having previous psychiatric problems.

Similarly, while we have been able to determine 'previous psychiatric histories' from our research into the backgrounds of the victims, it is clear that Correctional Staff, in handling a great number of these cases, at the time were not aware of the psychiatric state or 'histories' of these individuals.

Unless key staff are aware of previous mental illness, previous suicide attempts or have current reports of bizarre behaviour, the value of that information is all but totally wasted. Time and again in this system and in other Justice systems, one segment of the organization may know of an individual's mental health problems or suicide risk and fails to communicate this to other segments or key individuals.

While information on staff knowledge of victims previous mental illness is not available in our study or in the Federal Study, the American survey instrument shows that:

> "When asked whether there was any indication of mental illness in the victim prior to his/her death, 70% of the jailers said they were not aware of any."(16)

While showing that having a previous psychiatric history may be a flag to alert staff to potential problems we must be careful to emphasize that the current situation and how the individual is reacting is of greatest importance. Line staff, once aware of current and/or previous emotional upset in an inmate should alert professional staff or refer for an assessment of the case.

Once alerted, Case Management or Professional Staff should make every reasonable effort to gather significant background information on previous emotional problems through community contacts with probation, family and medical/psychiatric institutions/practitioners.

It now appears more important than ever that staff training encompass basic recognition of anxiety reactions, abnormal behaviour and the symptoms of mental illness. A knowledgeable staff that are aware of and sensitive to, the symptoms of these problems in inmates are of great benefit in mobilizing a coordinated response to suicidal behaviour.

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(16) NCIA, "Darkness Closes In, p. 35.

While a very credible program of training at the B.C. Justice Institute covers many of these issues for new staff in Training Blocks II and IV (interpersonal conflicts, recognizing symptoms of mental illness, institutional and emotional behaviour, abnormal behaviour and suicidal behaviour) there is a real need to expose older permanent staff to this training as well.

In response to a spate of suicides at LMRCC in the mid 70's, a special observation area in the South Wing was established for the care and observation of suicidal inmates. Because of the frequent difficulties in referring commitable and borderline psychiatric cases to psychiatric institutions in addition to the frequent court ordered psychiatric assessment transfers, it has been suggested that Corrections expand on the concept of a special observation wing. This idea would see establishment of a separate medical psychiatric institution or wing which would properly house suicidal inmates.

While it cannot be disputed that increased psychological /psychiatric services would be beneficial in combating suicide and assist in enhancing/maintaining a suicide prevention program, the reality is that we will not likely receive increased professional 'man-years' during times of financial restraint. Other strategies should be employed to increase our capabilities in reaching these two objectives regardless of whether we get the recommended professional services or not. Certainly a focus on early detection/identification of potential suiciders would increase the efficiency of the process and allow for the most strategic placement of suicide prevention resources.

A focus on the admission procedure, the admitting interview, particularly for remand inmates, would narrow and make more efficient the identification and handling process.

Institutions such as the new Pretrial Centre at 222 Main St., Vancouver, would be an excellent focal point for the "Psych-Screen" admission process. One of the corollary recommendations concerning suicide prevention strategies in relation to mental illness, flows from the need to have program activities for remand inmates.

The need to have meaningful activity, work and programs available to inmates who are still before the Court, has long been recognized but considered an "off limits" area where the state has no right to interfere (remand inmates are innocent until proven otherwise and are housed in our institutions to ensure appearance for Court and protection of the community).

Morally, however, we appear to have a responsibility to have programs, work and activity available to these individuals, particularly when the absence of same is devitalizing, destructive and often considered a contributing factor, direct or indirectly, to self-destructive behaviour.

Conclusions

It would appear evidence of a previous psychiatric history could be one of a very few indicators of an increased potential for suicide.

Of key importance is obtaining background information on the previous psychiatric histories on inmates who are currently experiencing anxiety or displaying serious upset.

Training all staff in the basics of recognizing the symptoms of stress, anxiety and/or mental illness will be a necessary key to the effective operation of a suicide prevention program.

Consideration be given to having guaranteed beds at the Forensic Psychiatric Hospital to ensure immediate transfer of commitable patients or alternatively establishing under Corrections, a separate medical/psychiatric facility for observation, assessment and care of suicidal, psychotic and observation inmates.

* * *

Forty-three year old John with a fairly steady work history, had a serious alcohol problem and was just beginning his third period of incarceration, three months for false fire alarm at A.R.C.C. in the spring of 1974.

Having been raised in London during the war years, his mental health problems seemed exacerbated by drinking leading to problem behaviour often ending in the setting of fires or sending in false fire alarms.

Following his second wife's suicide ten years before, he had increasingly frequent admissions to psychiatric care. In fact, he had been given a pass from his doctor at Riverview to attend Court on his current sentence while still under hospital care. He had shown many earlier suicide gestures.

To provide further information to the Court, his Doctor wrote a letter outlining John's problems and the fact that he was currently under care in a psychiatric facility. The

Psychiatrist later wrote to the Coroner explaining his surprise when the Court did not order John back to the mental hospital but instead, sentenced him to a short jail term. There is no record that this information was ever sent to A.R.C.C., or if sent, that it was ever shared with line or medical staff.

John was noted by staff to be in very poor physical health, had trouble sleeping and was not capable of any heavy work. Consequently, he was assigned to the "grounds", where "he could just putter around and perhaps regain some of his strength and health".

Two weeks after arrival at A.R.C.C., John had seen the nurse and was due to see the doctor the following day for one of his many medical complaints (anxiety and insomnia). He was not found on the grounds at the time of evening count and was declared A.W.O.L. John was found the following morning hanging from a pole near a river, "just out of bounds".

Key Factors For Consideration/Warning

1. Family problems, fearful childhood, divorce of first wife and suicide of second wife.

2. Poor health, anxiety, insomnia, D.T.'s alcohol withdrawal.

3. Previous suicide gestures.

4. Lengthy mental health/psychiatric background apparently not shared between Medical-Court-Corrections Systems.

INCIDENCE OF SUICIDE BY PREVIOUS ATTEMPTS

Consistent with previous studies and current research, we found 16 of B.C. Corrections 35 suicides under study had recorded previous suicide attempts, gestures or threats prior to the fatal attempt. Thus, almost half of these victims had previous attempts and a significant number of the 16 had multiple attempts in the past or prior to the final act. Of the 19 remaining, there may well have been unknown previous attempts that failed or were not meant to succeed; (manipulative) however, we were not able to find evidence on these cases. Perhaps, the most important factor that follows is the question of staff awareness of previous attempts.

While there are readily apparent difficulties in determining staff awareness of an offender's previous suicide attempt history or his psychiatric problems, we do know for certain that in several of our cases the victims were active suicide attempters and staff preventative techniques had been or were applied. In some instances, these techniques were effective for as long as they were applied but once relaxed, the determined suicide victim succeeded in his purpose. In a few instances, suicide prevention techniques that followed earlier attempts, were clearly not effective enough.

In recognizing the apparently strong link in our data of previous suicide attempts or threats with subsequent suicides, we are reminded in Burtch and Ericson's Canadian study that many other jurisdictions have had equally strong evidence of this connection. In Burtch and Ericson's own study of 96 Federal inmates who suicided, 40% had "previously manifested either suicide threats, suicidal ideation or an actual attempt to take their own lives".(17)

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(17) Burtch & Ericson, The Silent System, p. 55.

To address very briefly the question of suicide attempts in terms of volume in our system, we must rely on the data earlier supplied by LMRCC staff showing an eleven year total of 639 attempts (Table 13)

Table 13

INCIDENCE OF ATTEMPTED SUICIDES
L.M.R.C.C. 1967-1978

	Hanging	Slashing	Other*
1967	29	112	-
1968	42	90	3
1969	28	55	4
1970	17	45	7
1971	14	70	12
1972	14	42.	-
1973	10	41	5
1974	3	13	-
1975	6	8	-
1976	4	7	-
1977	4	3	-
1978	-	5	-
1979	No Records Maintained		
TOTAL	117	491	31

*Includes suicidal attempts by swallowing razor blades, glass, paint thinners, and attempted drownings.

We see there are a great many more attempts than actual suicides.

While it is acknowledged that the informal statistical recording of suicide attempts dropped off in the mid 1970's, there is no doubt that there was also, during this period, a dramatic drop in "actual" attempts. This drop in suicide attempts in our largest institutions, has been attributed to a number of factors:

1. The establishment of the Health Care Unit for more focused on-site care and attention to not only health care cases but cases of suicide potential.

2. The establishment of a policy to reduce levels of medication particularly tranquilizers, in the inmate population beginning in November 1969.

3. The establishment of the B.C. Justice Institute in April 1978 with Staff Training Programs in Psychology of Human Behaviour, Stress and Institutional Behaviour and Suicide Prevention.

4. The increase in psychological services beginning in 1973, with the establishment of a full time psychologist to augment sessional psychiatric visits in our institutions.

5. The decrease in staff turnover with the formation of the Union, better wages which appear to have combined for a more stable environment.

6. The gradual relief from overcrowding with the overall general decline in inmate population from 1970 to 1980.

While it would be impossible to assign a weight or value on which individual factor or groups of factors that were most significant in causing this decline, we will assume a combination of factors contributed to the reduction of suicide attempts.

A cautionary note is necessary with regard to attempt suicide statistics. There has been a recognized error factor in recent years with various institutions exercising a certain amount of "discretion" in reporting incidents of self-inflicted injury vis-a-vis attempt suicides. In some cases the event would be treated as non-reportable (a "scratch on the wrist"). In others, an accident report form might have been filed and in others, an "Incident Report Form" would have been submitted.

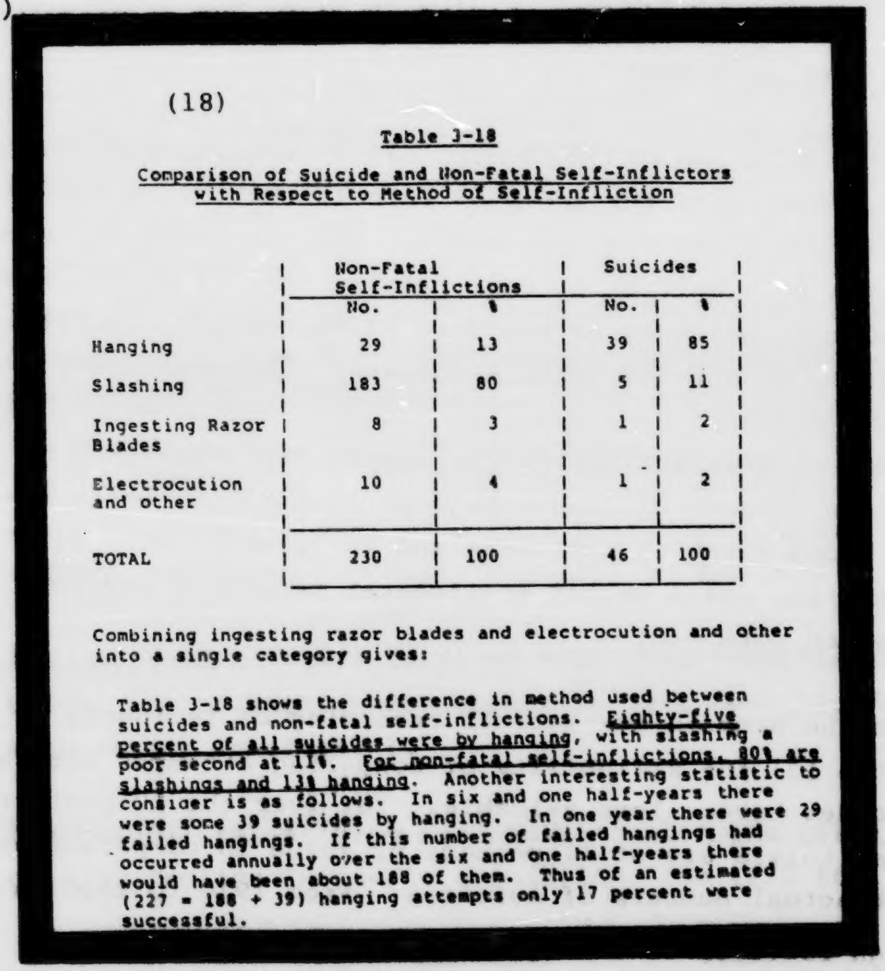
We also have the discretionary factor involving degree of injury. Generally the accepted rule is that, if a self-inflicted injury requires medical treatment then this can be designated a suicide attempt particularly if there is other supporting evidence in the form of depression, verbalized threats, or suicide notes associated with the injury.

By way of standardization the Branch has instituted in 1982 the new "Report Of Inmate Injury" Form #7615, which covers the broad gamut of accidents and injuries which will, hopefully, yield better statistical reporting and thus better research potential.

With the drop in statistical recording of incidents at LMRCC (Table 13) the reliability of comparing attempts with actual suicides became less valuable. Yet over the 10 year period, these totals are still perhaps of value in comparing attempts with actual numbers of suicides. From 1970 to 1980 we see a rough ratio of 25 attempts to 1 suicide.

We note, at LMRCC in 1981, there were 30 recorded self-inflicted injuries compared with 3 suicides while in 10 months ending October 1982, there are approximately 40 recorded attempts or self-inflicted injuries and no suicides. As we shall see in discussion, on the topic of "Method of Suicide", there are fewer hangings attempted compared with slashing attempts by a wide margin. Generally, 'hanging' is by far the most lethal suicide technique compared with slashing which is very seldom fatal.

While we do not have incidence rates to compare in the B.C. data, we will rely on the Federal Study to show this factor. (18)



(18)

Table 3-18

Comparison of Suicide and Non-Fatal Self-Inflictors with Respect to Method of Self-Infliction

	Non-Fatal Self-Inflictions		Suicides	
	No.	%	No.	%
Hanging	29	13	39	85
Slashing	183	80	5	11
Ingesting Razor Blades	8	3	1	2
Electrocution and other	10	4	1	2
TOTAL	230	100	46	100

Combining ingesting razor blades and electrocution and other into a single category gives:

Table 3-18 shows the difference in method used between suicides and non-fatal self-inflictions. Eighty-five percent of all suicides were by hanging, with slashing a poor second at 11%. For non-fatal self-inflictions, 80% are slashings and 13% hanging. Another interesting statistic to consider is as follows. In six and one half-years there were some 39 suicides by hanging. In one year there were 29 failed hangings. If this number of failed hangings had occurred annually over the six and one half-years there would have been about 188 of them. Thus of an estimated (227 = 188 + 39) hanging attempts only 17 percent were successful.

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(18) C.S.C., Self-Inflicted Injuries and Suicide, p. 62.

It would appear, as displayed in the Corrections Service Canada report that the method chosen may show the intent of the would-be victim. Those chosing slashing to be more likely manipulating or less desirous of actual death than those who chose hanging as their method of attempt.

CONCLUSIONS:

There are many more attempted suicides than actual suicides.

Many attempted suicides are planned, non-lethal events quite often designed for attention getting or other manipulative purposes such as securing transfer or gaining relief from an anxiety producing situation.

There are strong indicators that successful suicides were preceeded by attempts and in some cases, many attempts, by the victim.

Every attempted suicide must, therefore, be looked at as serious.

The importance of accurate reporting of incidents of self-destructive behaviour and attempts at suicide on "Report of Inmate Injury" form is essential in the process of analyzing and gaining an understanding of destructive behaviour in our institutions.

* * *

Twenty-year old Ronald was found 15 minutes after midnight, hanging by a bedsheet from the top bars of his unit #1 cell at Prince George Regional Correctional Centre on September 11, 1975. Ronald had served one month on remand awaiting trial for a serious wounding with intent charge from Quesnel, B.C. According to the police report, Ronald who had a fixation with knives and weapons, had thrown a hunting knife at a friend during an argument while both had been drinking. His criminal record was predominately laced with offences against persons; armed robbery, arson, wounding, possession of weapons and escape.

Apparently, during juvenile detention, he had successfully escaped but returned with a knife to free all the other boys from the Manitoba Boys Home.

Going back one step further, we understand Ronald had a very unhappy childhood marked with parental divorce, death of a parent, parental abuse and his other siblings involved in social and legal problems.

Ronald, upon leaving Manitoba, married and was very attached to and dependant on his wife and young son. He was extremely upset with the prospect of losing contact with them following arrest.

R.C.M.P. Officers at the time of arrest noted that he was suicidal after he made one attempt in police cells and they learned from probation and parole authorities of his previous suicide attempts both in jail and out.

This information was relayed to P.G.R.C.C.'s staff who initially took precautions but gradually relaxed as Ron appeared to settle down.

A parole officer who interviewed him on August 12, felt he was alright; however, several inmates noted that Ronald had become depressed regarding his wife's plan to return to

Winnipeg with their son. He talked of suicide with inmates; however, staff were apparently unaware of his changing circumstances and feelings. He was described as friendly with staff and other inmates, did not complain and had no medical problems.

Ronald was in an unusual situation in a unit where two other inmates who had been threatening suicide were being watched. His reason was clearly spelled out in his suicide letters; however, his note perhaps expresses it best, "I have lost my wife and son which leaves me with nothing".

Key Warning Signs/Factors For Consideration

1. Multiple problem background with poor self-image and lack of confidence. Inmate's one key community resource was leaving the picture.

2. Previous sucide attempts including recent suicide attempt.

3. The presence of other prisoners attempting suicide (it is interesting to note that the only other suicide in P.G.R.C.C.'s history occurred within 5 days of Ronald's).

4. Having initially been alerted to this inmate's suicide potential, staff relaxed their vigilance when he appeared to present himself in a normal controlled and friendly manner.

PRECIPITATING EVENT:

A review of the literature reveals that experts in the study of suicide believe a culminating or precipitating event often preceeds the victims attempt to solve or escape his perceived problems, anxiety or stress by taking his or her life.

Assessing motivation for suicide and thus evaluating the precipitating factors is, and will always be, fraught with difficulties. We are, after all, attempting to understand from the victims perspective, the insurmountable problems or pressures confronting that person.

> "The search for causation in suicide is necessarily precarious for we can only construct several events related to the deceased and then speculate as to what events may have precipitated the fatal act". (19)

Having thus described the need for caution , and delineating the essential ingredient of care in interpreting motivation, we may still gather valuable indictors as to the causes of many inmate sucides.

This may be accomplished by closely examining the individuals physical and psychological environment (milieu) preceeding the fatal suicide attempt. The psychological autopsy is the vehicle used by professionals in other disciplines to inquire into the motivating factors behind successful suicide. (For an outline of the psychological autopsy, see Dr. P. Termanson's work Appendix D).

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(19), Burtch & Ericson, The Silent System, p. 67.

Our attempts in this study to assess motivation are based on file review, Coroner's Inquests, staff interviews, review of . psychiatric reports (where available), pre-sentence reports, contact with family, friends, fellow inmates and Correctional Staff. Victim's suicide notes, behavioural indicators, histories of previous attempts, and psychiatric histories, give data on which to assess motivation and where possible, determine culminating events.

Behavioural indicators in our study range from, active suicide attempts (even though often described as "attention getting" or "manipulative" self-inflicted injury), though social withdrawal from other inmates and staff, to (perhaps an unusual indicator) that of inappropriate calm or even mild elation prior to the fatal attempt. In the latter instances, the decision to escape from problems through suicide having been made, there may be a "calm" (or relief) noted in retrospect by fellow inmates or staff.

Almost by definition we accept that the culminating or precipitating event is most likely not the single motivator but perhaps the last or final motivator in a complex pattern of pressures or perceived pressures. Thus, while we tend to look for the 'trigger' that immediately preceeded the final act, we will also weigh other factors and rank these in terms of importance to a particular case. Thus a sole or single motivator will be seen in Table 14 (p.69), as a "primary motivator" while the next most significant factors will be tabulated "important" and "secondary motivators" in descending order of assessed impact on a case. In the construction of Table 14 we have excluded Previous Psychiatric History, Previous Suicide Attempts and History of Suicide in the Family, as these factors, though perhaps important, do not seem to fit well into the definition of "Precipitating Events" .

Table 14

Analysis of Precipitating Event
In Suicides B.C. Corrections1970-1980

Loss of Significant Person(s) (girl friend, wife,boyfriend, husband family)		
Primary Motivator	3	
Important Motivator	9	
SecondaryMotivator	3	
		15
Conflict with Significant Person(s) (wife, girlfriend, husband)		
Primary Motivator	-	
Important Motivator	2	
Secondary Motivator	1	
		3
Fear (trial, sent,transfer to Penitentary, deportation, inmate harrasment)		
Primary Motivator	1	
Important Motivator	4	
Secondary Mortivator	5	
		10
Anger (trial, sentence, new charges, treatment,medication)		
Primary Motivator	-	
Important Motivator	2	
Secondary Motivator	6	
		8
Drug Reaction (withdrawl, flashbacks)		
Primary Motivator	-	
Important Motivator	2	
Secondary Motivator	3	
		5
Alcohol Reaction (hallucinosis, D.T.s poor health)		
Primary Motivator	2	
Important Motivator	-	
Secondary Motivator	3	
		5
Current Psychiatric Problems (depressed, paranoid, martyr,schizophrenic)		
Primary Motivator	1	
Important Motivator	2	
Secondary Motivator	1	
		4
Remorse / Disgrace		
Primary Motivator	-	
Important Motivator	2	
Secondary Motivator	1	
		3
Poor Self Concept		
Primary Motivator	2	
		2
Health Deterioration		
Primary Motivator	-	
Important Motivator	1	
Secondary Motivator	2	
		3

Despite the low numbers of suicide cases, the analysis of motivating factors may be still viewed as significant.

We feel confident in identifying the sole or "primary" motivators in 9 of our 35 cases. These were mainly in circumstances where the victim left a note or clearly indicated to those around him the reason for his decision to suicide. In addition, factors of key "importance" are identified in 24 cases while approximately 25 of the 35 cases appeared to display the presence of other "secondary: motivators.

Four cases presented little or no indications of reason for suicide; two victims were almost totally noncommunicative, one faced deportation and one, a case of strangulation, may have been an accident. In the latter instance the victim was found in his bunk with a towel wrapped around his neck, which some believed was used by the the the victim to obtain an "artificial high".

Motivation in the latter instance must be considered "unknown" even though classed as suicide by the Coroner's Inquest.

Getting back to those cases where motivators were indicated, we see that "loss of a significant person" shows up as the most pronounced factor in terms of volume. Not only are the highest number of primary motivators for suicide associated with loss of a girlfriend, wife or family, the greatest number of important motivators are also in this category. On the other side of the coin, loss of support and disruption resulting from "conflict with the significant person" is a category, though small, which could be combined with loss of significant person (i.e., support) for even greater emphasis of this point.

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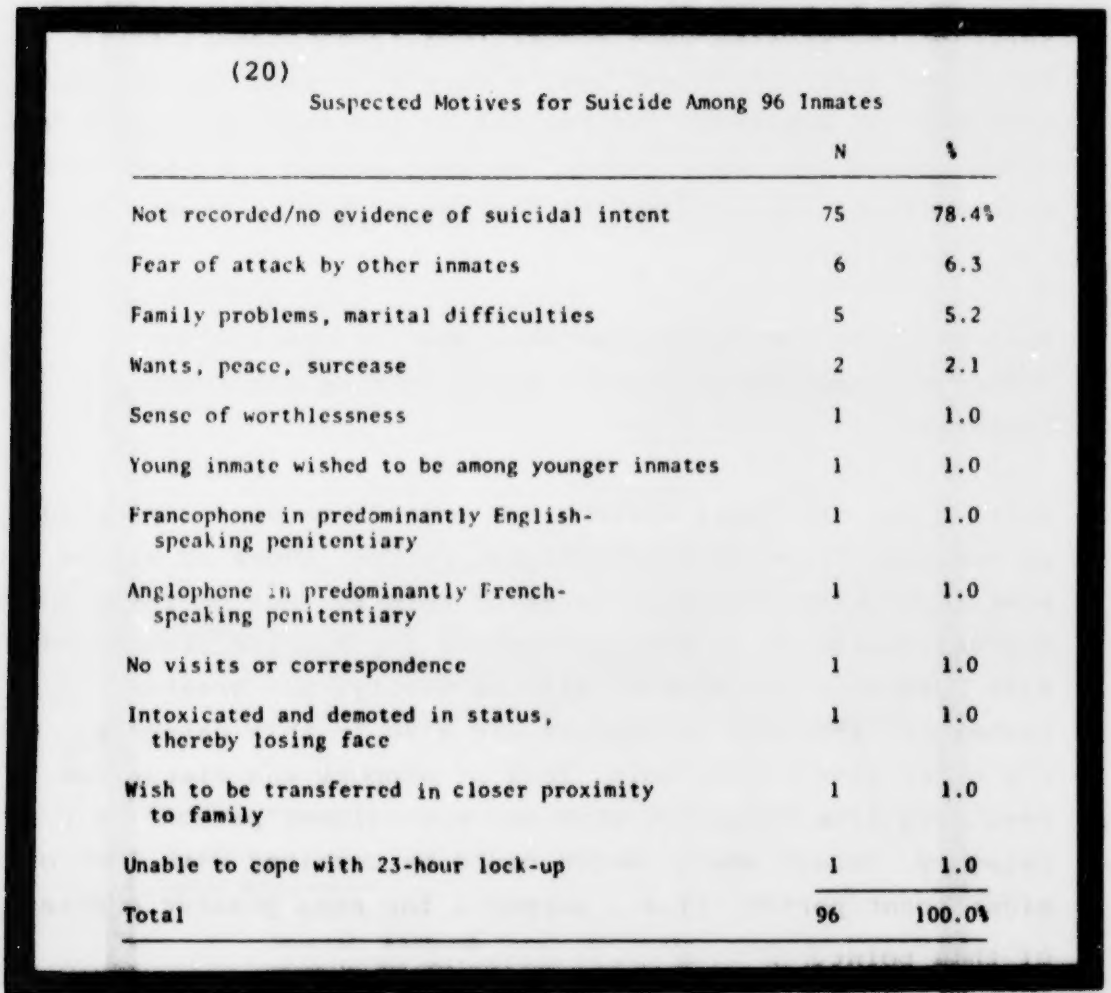
(20) Burtch & Ericson, The Silent System, p. 59.

The motivating factors of fear and anger are tied for second position of importance while drug/alcohol reactions and current psychiatric problems are roughly ranked equal in third position. Remorse/disgrace, poor self-concept and deteriorating health are all roughly tied for the last place in identified motivational factors.

It is interesting to note that although the U.S. and current Canadian C.S.C. studies did not look at victim motivation, Burtch and Erickson addressed this matter briefly in their research, see insert, "Suspected Motives for Suicide Among 96 Inmates." (20).



(20)

Suspected Motives for Suicide Among 96 Inmates

	N	%
Not recorded/no evidence of suicidal intent	75	78.4%
Fear of attack by other inmates	6	6.3
Family problems, marital difficulties	5	5.2
Wants, peace, surcease	2	2.1
Sense of worthlessness	1	1.0
Young inmate wished to be among younger inmates	1	1.0
Francophone in predominantly English-speaking penitentiary	1	1.0
Anglophone in predominantly French-speaking penitentiary	1	1.0
No visits or correspondence	1	1.0
Intoxicated and demoted in status, thereby losing face	1	1.0
Wish to be transferred in closer proximity to family	1	1.0
Unable to cope with 23-hour lock-up	1	1.0
Total	96	100.0%

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(20) **Burtch & Erickson, *The Silent System*, p. 69.**

CONCLUSIONS:

Given many difficulties in assessing suicide motivation, we are still able to roughly rank the most important motivating factors as:

(1) loss of significant person(s);
(2) fear, anger;
(3) drug reaction, alcohol reaction, current psychiatric problems;
(4) remorse/discgace, poor self-concept and
(5) deterioration of health.

Correctional staff while realizing motivational factors, may be different for each inmate under their care, (masked or identifiable) may nevertheless be sensitized to the importance of communicating with their inmate charges to constantly assess mood, problems, anxieties and concerns.

Correctional staff, on recognizing the potential motivators, can make the single most important contribution in suicide prevention by discussing the inmate's problems, concerns, anxieties and neutralizing where possible or referring for special medical or psychiatric services.

* * *

Charged with the shotgun murder of his wife, 64 year old Thomas was found hanging on Monday Sept. 15, 1975, at P.G.R.C.C. the day his trial was to have commenced. Inmates returning from exercise at 1345 alerted officers who found he had hung himself with his bedsheet attached to overhead bars of his remand cell after first slashing his stomach.

Thomas, a bad tempered perfectionist who despite his stormy marriage was proud of his family, had shot his wife after drinking heavily the day she carried out her threat to separate and move out of the family home.

Thomas, who had been an average citizen, productive farmer, mechanic and business man, was finding his first time in jail a shock. This coupled with remorse over loss of his wife and conflict with younger inmates, led to increasing anger and despair. After a psychiatric examination at Riverview in June 1975, he was returned to Prince George where a series of remands leading up to his trial apparently left him even more frustrated. Refused bail because authorities and family felt he was suicidal and would be safer in custody, Thomas became increasingly upset with delays.

Assessed shortly after the offence in April as suffering from "acute depression with paranoiac personality" the psychiatrist saw him Sept. 10, just 5 days before his demise, and again noted the "suicide risk". Combined with his legal problems and personal loss, Thomas was suffering poor health with an infected foot, requiring crutches. He was also having difficulty sleeping, and as a result required four different kinds of medication.

Having fought with his lawyers over bail and lengthy delays, he warned them that he did not want to live with pain--he'd lived a full life and didn't want to live in pain in jail. Thus having told his lawyers he would end it all if he didn't get out he warned staff on August 2, "You will find me hanging from the bars soon".

The last minute delay of his trial the morning he had anticipated it would go ahead (with no word from the Court as to reason for delay or further setting of a date), seemed to be the final straw. It is interesting to note, the only other suicide that was ever successful at PGRCC happened 5 days before by a fellow-remand inmate.

Key Factors For Consideration/Warning

1. Loss of significant person, shock of initial incarceration, poor health, conflict with fellow- inmates and loss of family support.

2. Psychiatric assessment, acute depression 'and paranoiac personality' who was clearly suicidal having threatened lawyer, staff and inmates.

3. Psychological influence of recent suicide of fellow-remand inmate.

4. Final straw, the last minute unexplained delay of trial after 'agonizing' wait.

PART V

VICTIM STATUS

INCIDENCE OF SUICIDE BY STATUS BEFORE THE COURT

It has been suggested that inordinately high incidents of suicide occur during the remand (pre-trial and pre-sentence) period as a function of anxiety, tension and fear of the unknown. This is most often the time when concerns about loss of job and family abondonment heighten while self-esteem and independence plummet. Our data certainly displays this disproportionate rate of incidence whatever the dynamics of individual motivation.
(Table 15)

Comparison Of Suicides In Relation To Court Status
B.C. Corrections 1970-1980

	No.	Percentage Proportion	Totals	Percentage Inmate Population	
Remand Inmates	21	60.0%	71.4%	39%	Remand
Remanded (Immigration/ Deportation)	3	8.6%			
New Charges Pending	1	2.8%			
Sentenced Inmates Sentenced	10	28.6%	28.6%	61%	
TOTALS	35	100%	100%	100%	

For comparative purposes and practical reasons we have lumped the Detain for Immigration cases and the case of a sentenced inmate awaiting further serious charges in with the remand group. Certainly, there are close similarities in the circumstances of inmates in these three categories.

It appears that in our system approximately 71% of the suicides occur in the remand population that only constitutes 39% of the inmate population. The sentenced inmates, 61% of the population, have only 29% of the suicides. (Figure 6) p. 78.

In that the Canadian Penitentiary Study deals exclusively with sentenced inmates, there would be no point in attempting to compare on this factor. As a result, we looked at the American data to see what similarities and differences exist.

21) Jail Status (NCIA U.S.)

	No.	Percentage
Detained (Remand)	308	91.4%
Sentenced	29	8.6%
	337	100.0%

> The N.C.I.A. Report concludes, "As can be seen,the overwhelming majority (91.4%) of suicide victims were on detention status at the time of their death." (22)

To simply display this data for comparison we see the ratio:

Table 16

Incidence Of Suicide By Court Status
Comparison Of Two Studies

	B.C.	N.C.I.A.
Remand (Detain) Inmates	71.4%	91.4%
Sentenced Inmates	28.6%	8.6%

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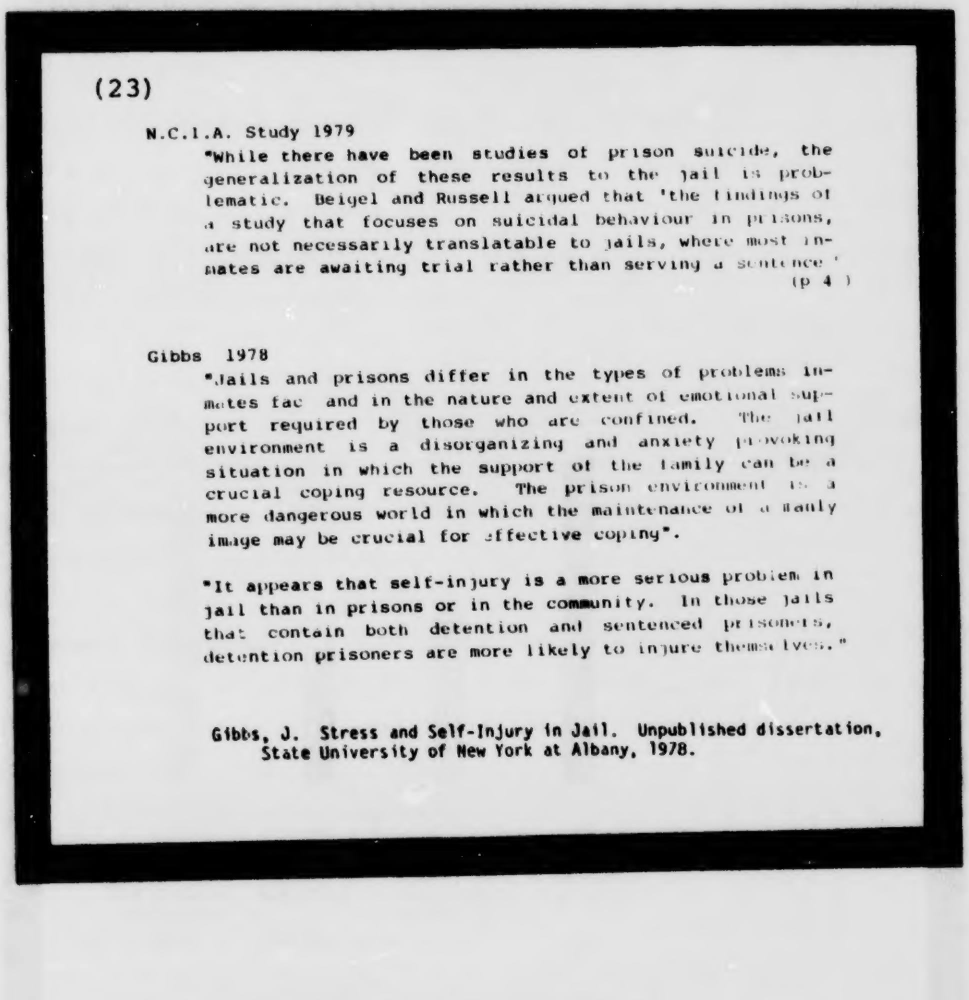
(21) NCIA, Darkness Closes In, Reprint, Table 10, p. 26.

(22) Ibid, p. 25.

While the balance is in the same direction (higher for remand - detainees), the rate is greater by 20% in the American Study. This we believe can be accounted for by the fact that the American Survey instrument received a much heavier response from jails or "lock-ups" where suicide rates are considered highest. (See insert 23.)



(23)

N.C.I.A. Study 1979

"While there have been studies of prison suicide, the generalization of these results to the jail is problematic. Beigel and Russell argued that 'the findings of a study that focuses on suicidal behaviour in prisons, are not necessarily translatable to jails, where most inmates are awaiting trial rather than serving a sentence.'
(p 4)

Gibbs 1978

"Jails and prisons differ in the types of problems inmates face and in the nature and extent of emotional support required by those who are confined. The jail environment is a disorganizing and anxiety provoking situation in which the support of the family can be a crucial coping resource. The prison environment is a more dangerous world in which the maintenance of a manly image may be crucial for effective coping".

"It appears that self-injury is a more serious problem in jail than in prisons or in the community. In those jails that contain both detention and sentenced prisoners, detention prisoners are more likely to injure themselves."

Gibbs, J. Stress and Self-Injury in Jail. Unpublished dissertation, State University of New York at Albany, 1978.

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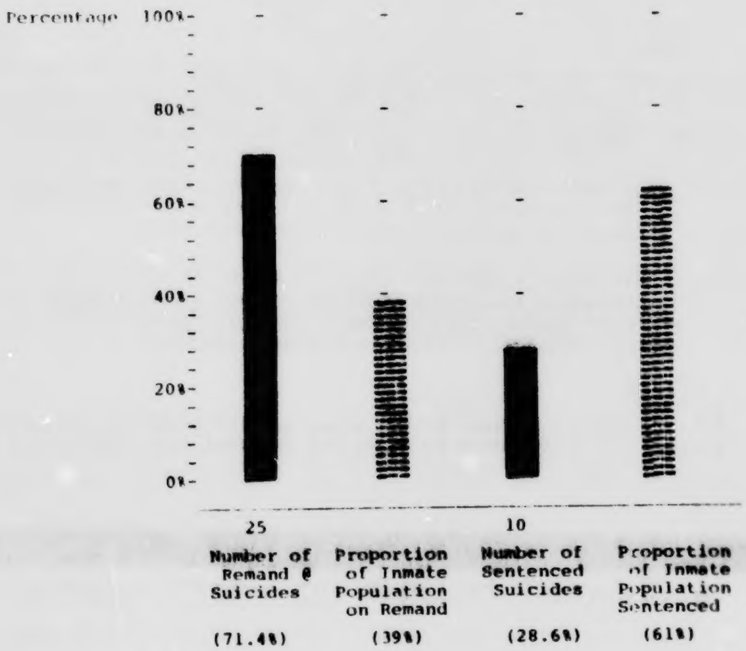
(23) Ibid, pp. 4-5.

These observations certainly appear to be born out in our suicide study as data on self-inflicted injury at L.M.R.C.C.

To more accurately determine the significance of the higher rate of suicide of B.C.'s remanded inmates, we went one step further to actually examine this occurrence rate in light of the proportion of inmates in these two categories. (Figure 6)

Figure 6

INCIDENCE OF SUICIDE BY STATUS BEFORE THE COURT
B.C. CORRECTIONS
1970 - 1980



@ Remand figures include 3 held for deportation and one sentenced inmate awaiting trial on new serious charge

The real significance in identifying the remand population as being in greater jeopardy from a suicide standpoint is the realization that we are concentrating the majority of our remand population in the new Vancouver Pretrial Services Centre at 222 Main St., in Vancouver. This has become the focal point for remand inmates on the Lower Mainland of B.C. and thus the institution where we should concentrate our suicide prevention activities.

CONCLUSIONS

In regard to status before the Court, we can readily see 70% of our inmate suicides occur in the remand group which accounts for only 40% of our inmate population. Therefore, it would appear that our remand inmates are in much greater jeopardy from a suicide standpoint.

Suicide intervention programs would best be initially aimed at the remand population and the dynamics at work in the remand inmate groups. Therefore a focal point in our immediate suicide prevention program should center on the new Vancouver Pretrial Services facility.

All remand staff at the Pretrial Services Centre should be trained and certified in first aid, C.P.R., and receive the most advanced training available in suicide prevention techniques.

* * *

Twenty year old John had served almost 2/3rds of his 18 month sentence when he was involved in a major disturbance at a Forestry Camp and escaped. Recaptured and returned to maximum custody, he faced new charges which would most likely see him transferred away from his community resources to a Federal Penitentiary. Almost three weeks after recapture he set fire to his cell after barricading the door and wiring the door shut. He died almost a month later in a hospital burn unit.

Considered a problem inmate, John was described as violent and aggressive when drinking. From early childhood, when he witnessed family beatings from an abusive father, he had problems with authority. His criminal record which grew from juvenile property offences to increasingly serious crimes against persons with weapons, reflected his personality problems particularly "when under the influence." His current problems were believed to have been triggered when he "got into a brew" at camp.

John had been an active suicide attempter during a previous penitentiary term, at home prior to initial arrest and immediately following recapture. Most of his attempts were considered attention getting and not serious. On the night that he set fire to his cell and was fatally burned, he had earlier slashed his wrists and started a small fire in his end-of-tier cell. Other inmates recruited by the staff in the earlier instance, had been successful in convincing him to remove barricades and get assistance from staff.

The Coroner's Inquest was told that he had a great fear of the penitentiary where he had reportedly been the subject of sexual attacks during an earlier sentence. He was also very concerned about losing his girlfriend due to his apparently bleak prospects. Having been seen by a psychiatrist a month before for "situational depression" he had been taken off anti-depressant medication as he had shown improved outlook.

Key Factors for Consideration/Warning

1. Victim facing new serious charges which were seen to likely result in transfer and a return to jeopardy in the penitentiary.

2. The victim's one significant relationship, that with his girlfriend, was certainly threatened by these prospects.

3. Victims previous suicide attempts, including one earlier the same day.

4. In view of the victim's attempts, there seemed an increased need for surveillance and perhaps a change of cell to bring him under closer visual contact.

5. Staff use of inmate relationships in a positive way to help in suicide attempts.

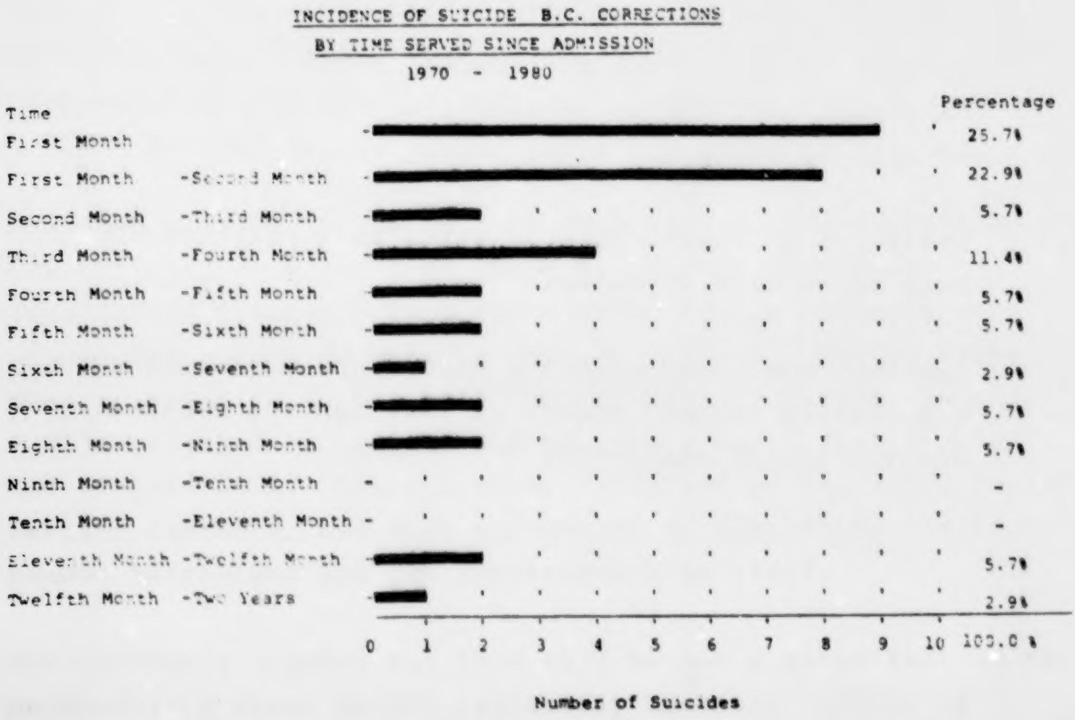
6. Institutional readiness for the unforseen emergency, e.g. having regular checks of firefighting capability and functional equipment.

INCIDENCE OF SUICIDE BY TIME SERVED SINCE ADMISSION

One of the most alarming findings of the N.C.I.A. Study was that 50% of the suicide victims died within the first 24 hours of incarceration, most often before appearance in American Courts. In fact, it was found that 27% occurred within the first three hours. These findings were quite likely due to the fact that heavy contributors to the American Jail Study were local lock-ups and Police detention cells. Possibly a study of suicides in Canadian Municipal Police lock-ups and detention cells would show a similar heavy suicide incidence rate on, or shortly after, arrest.

The following pattern of suicides in relation to time served since admission was found in our study (Figure 7).

Figure 7



We note approximately 50% of our suicides occur within the first two months of incarceration and half of these within the first three weeks.

Figure 8 provides a refinement in displaying the data "Times Served Since Admission" showing by weeks served.

Figure 8

INCIDENCE OF SUICIDE B.C. CORRECTIONS

BY WEEKS SERVED SINCE ADMISSION

1970 - 1980

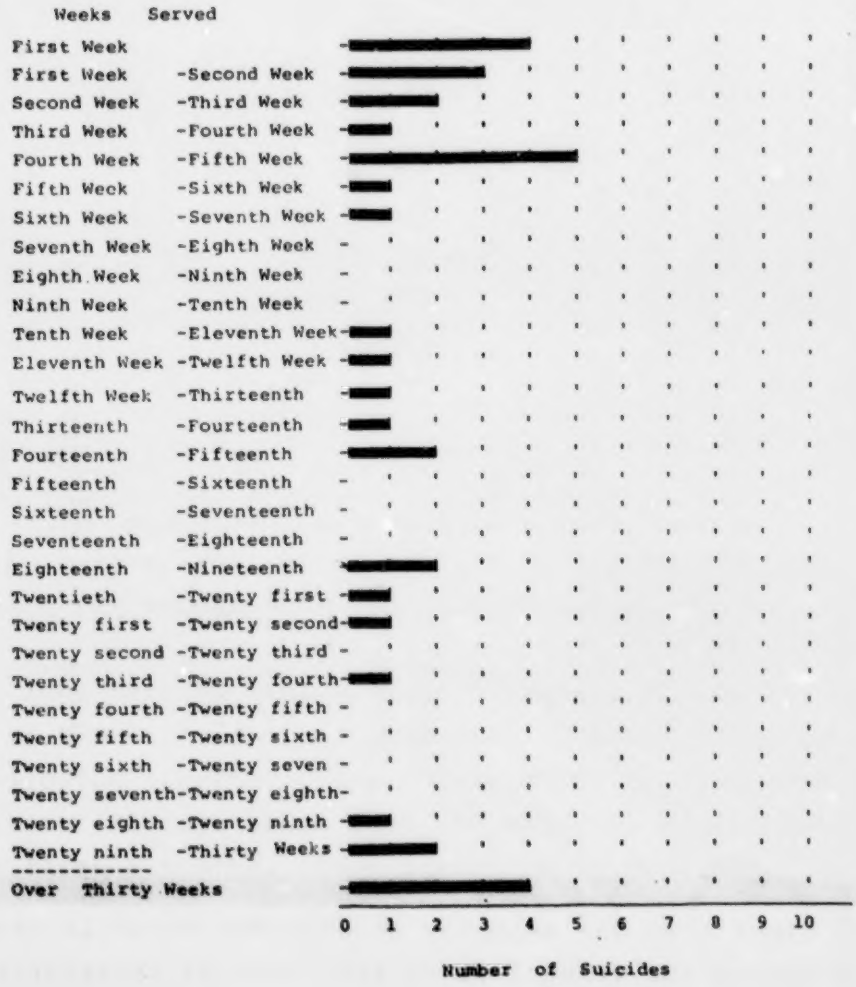


Figure 9 provides a breakdown depicting both remand population and sentenced cases.

Figure 9

INCIDENCE OF SUICIDE BY TIME SERVED SINCE ADMISSION
COMPARING REMAND AND SENTENCED INMATES

Week	Days	Remand Only	Sentenced Only	Both
1st	1 - 7	4	-	4
2nd	8 - 14	3	-	3
3rd	15 - 21	2	-	2
4th	22 - 28	1	-	1
5th	29 - 35	3	2	5
6th	36 - 42	-	1	1
7th	43 - 49	-	1	1
8th	50 - 56	-	-	-
9th	57 - 63	-	-	-
10th	64 - 70	-	-	-
11th	71 - 77	1	-	1
12th	78 - 84	1	-	1
13th	85 - 91	1	-	1
14th	92 - 98	1	-	1
15th	99 - 105	2	-	2
16th	106 - 112	-	-	-
17th	113 - 119	-	-	-
18th	120 - 126	-	-	-
19th	127 - 133	-	-	-
20th	134 - 140	1	1	2
21st	141 - 147	-	1	1
22nd	148 - 154	-	1	1
23rd	155 - 161	-	-	-
24th	162 - 168	1	-	1
25th	169 - 175	-	-	-
26th	176 - 182	-	-	-
27th	183 - 189	-	-	-
28th	190 - 196	-	-	-
29th	197 - 203	1	-	1
30th	204 - 210	2	-	2
31+up	211 + up	1	3	4
	Totals	25	10	35

It is clear that the majority of suicides occur in the remand group during the first five to six weeks of incarceration.

A further break down of our statistics by number of days served gives the definitive picture that the first hours, days and even weeks are not the most critical in terms of suicide incidents. (Table 17.)

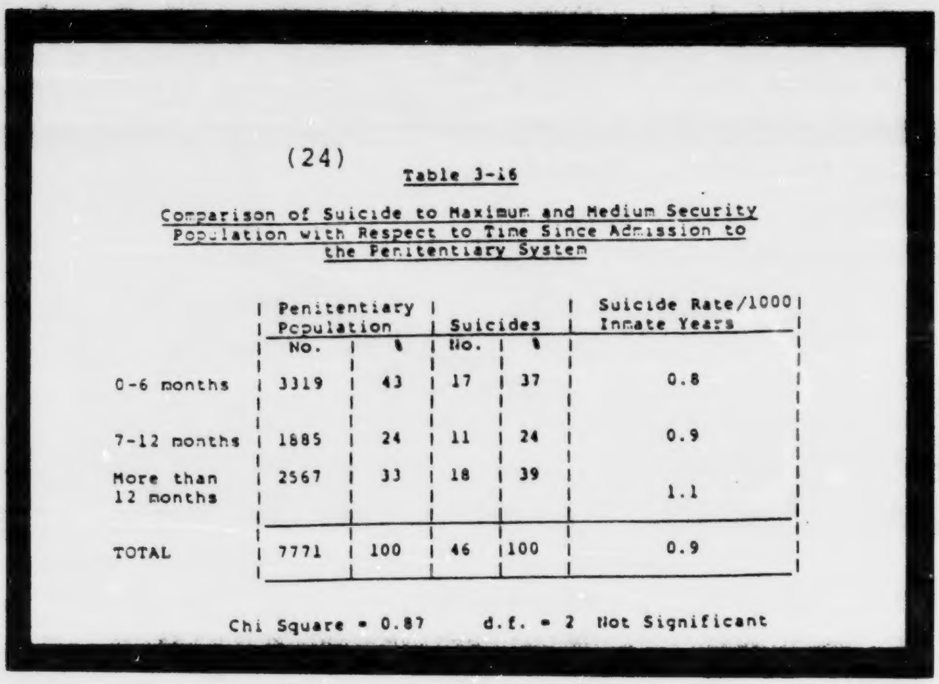
Table 17

INCIDENCE OF SUICIDE B.C. CORRECTIONS
BY DAYS IN CUSTODY SINCE ADMISSION
1970 - 1980

Days Served	No. of Suicides	Days Served	No. of Suicides	Days Served	No. of Suicides
First	1	65 to 75	1	145 to 155	-
1 to 5	2	75 to 85	1	155 to 165	1
5 to 15	4	85 to 95	2	165 to 175	-
15 to 25	2	95 to 105	2	175 to 185	1
25 to 35	7*	105 to 115	-	185 to 195	1
35 to 45	1	115 to 125	2	195 to 205	-
45 to 55	-	125 to 135	-	205 to 215	2
55 to 65	-	135 to 145	1	Eight Month	2
				Eleventh Month	2

Table 17 in conjunction with the data from Figures 7, 8 and 9 show the most crucial times to be just approaching and beginning the second month of incarceration.

Corrections Service Canada did a similar analysis on the basis of time served since admission to the penitentiary. The following reprint of their data while not delineating the time factor to days shows that the majority of suicides occur in the first 6 months. (See insert 24 on page 86).



(24)

Table 3-16

Comparison of Suicide to Maximum and Medium Security Population with Respect to Time Since Admission to the Penitentiary System

	Penitentiary Population		Suicides		Suicide Rate/1000 Inmate Years
	No.	%	No.	%	
0-6 months	3319	43	17	37	0.8
7-12 months	1885	24	11	24	0.9
More than 12 months	2567	33	18	39	1.1
TOTAL	7771	100	46	100	0.9

Chi Square = 0.87 d.f. = 2 Not Significant

CONCLUSIONS

While there appears to be a higher incidence of suicides after three weeks of incarceration, there seems to be no time during a term of imprisonment that is safe from a suicide prevention stand point.

It would appear that there are suicides that occur during the initial entry stages (when presumeably observation is potentially best and the assessment process is still underway). However, there are many suicides that occur when the victim could be considered to be over the hurdle of adjustment and these are quite unforseen by staff. Vigilance, again, is seen as the key of suicide prevention.

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(24) C.S.C. Self Inflicted Injury and Suicide, p. 61.

* * *

Mark, a 27 year old transient from Ontario, reportedly entered B.C. in 1974. Four years later on July 18, 1978, he was found hanging in his segregation cell at L.M.R.C.C.'s Westgate 'A', just hours after admission.

According to reports, Mark came from a negative home environment, where all 5 children left home in their mid-teens, all had Court records and most had serious drug problems. Parents, divorced in 1972, with alcohol and psychiatric problems percipitating family breakdown.

Mark existing on Social Assistance, marijuana sales and odd jobs, commenced his criminal history as a juvenile with simple property offences. His criminal pattern became progressively more serious as he netted convictions for robbery, assault cause bodily harm and a weapons charge as he endeavored to supply his growing heroin habit in Vancouver.

The sequence from his arrest on July 16, until suicide early on July 18th, was fast moving and underscored his aggressive impulsiveness. Arrested for multiple charges of B&E, police had reason to believe he was carrying drugs.

Violently resisting search, he later told police in the lock-up that he had just taken a 150 valium. Appearing groggy and falling in his cell, police took him to Vancouver General Hospital followed by admission to LMRCC early on the afternoon of July 17th.

Having been placed in the await trial unit, he attacked a protective custody inmate and as a result, was housed in the segregation unit following a trip to the hospital where he demanded medication and objected to his placement in the segregation unit.

Mark had a previous history of problems at LMRCC, was abusive towards staff and assaultive toward other inmates. He was apparently in a downward spiral, frustrated and angry, particularly over the amount and "quality" of his medication. He informed a fellow inmate that he would "make them sorry for not treating him better". The inmate told no one.

The autopsy showed traces of morphine which would have been consistent with his drug taking prior to admission, indications of injuries were examined closely at the inquest as charges had been made that Mark had been beaten prior to admission to LMRCC. Certainly, it was impossible to determine how much his own struggle and drug taking contributed to the condition in which he was found on admission.

Key Warning Signs and Factors For Consideration

1. Impulsive, acting out inmate still under the influence of drugs or suffering withdrawal from drugs presents a special management problem.

2. Assaultive, abusive behaviour coupled with medical problem accentuates the need for special segregation and observation.

3. Frustration and anger may have been key factors in his impulsive decision to suicide and perhaps in some perverse way to "get even with the system".

INCIDENCE OF SUICIDE BY STAGE OF SENTENCE

Closely tied in to "Status Before the Court" and "Time Served Since Admission" is the stage of sentence or stage of court process in which the inmate victim finds himself. As we have learned, the greatest majority of victims were on remand; however, the process with respect to the time sequence may be significant.

To basically portray this information, we begin with a continuum of the process and show a numerical count of the number of suicides at each stage. To add a further qualitative factor, the number of victims who were considered to be facing serious charges are shown in brackets See Table 18.

Table 18

INCIDENCE OF SUICIDE B.C. CORRECTIONS
BY STAGE OF COURT PROCEEDING OR SENTENCE
1970 - 1980

	Stage	Number of Suicides	Those Facing Serious Charges
Remand	Trial Date Unknown	12	(6)
	Trial Date Known	2	–
	Preliminary Hearing	1	–
	Committed for Trial	5	(4)
	Trial Underway	1	–
	Pre-Sentance Stage	1	(1)
	Pre-Deportation	3	(2)
Post Sentence	Pre-Penitentiary Transfer	3	(3)
Serving Sentence	First Quarter of Sentence	–	–
	First Third of Sentence	–	–
	Half of Sentence	4	(1)*
	Two Thirds of Sentence	1	
	Three Quarters of Sentence	2	–
	Pre-Release	–	–
	Totals	35	17

* Note: one victim had served over half of his sentence when he incurred new serious charges-no trialdate.

The data from Table 18 is further broken down in Table 19 to show the timing of suicides in relation to the judicial and sentencing processes.

Table 19

Incidence Of Suicide By Days In Relation To Court Proceeding Or Sentence B.C. Corrections 1970-1980

Trial Date Unknown	Trial Date Known	Preliminary Hearing	Committed For Trial
12	2	1	5
1st day	5th day	90th day	16th day
5th day	75th day		30th day
10th day			30th day
12th day			35th day
16th day			90th day
30th day			
84th day			
97th day			
101st day			
4.5 months			
7 months			
8 months			

Trial	Pre-Sentence	Pre-Deportation	Pre-Penitentiary
1	1	3	3
7 months	5.5 months	4th day	33rd day
		7th day	5 months
		6.5 months	8 months

Suicides in Sentenced Group

Beginning	1/4	1/3	1/2	2/3	3/4	Pre-Release
Nil	Nil	Nil	4	1	2	Nil

In examining this data for significance it simply appears that the largest proportion of suicides occurred in the remand (Pretrial) group in no set pattern.

Suiciding sentenced inmates in our study tended to congregate at the halfway point of their sentence but not beyond the three quarters mark of their term of incarceration.

CONCLUSION

Perhaps the only conclusions to be drawn regarding the factor of suicide by stage of sentence are that the preponderance of suicides occur in the remand pretrial stage. Suicides, thereafter, occur in all stages of the judicial and sentence process with the exception of the pre-release phase where suicides are rare.

* * *

Hudson, a 33 year old native from coastal B.C. was found hanging in his LMRCC West Wing cell one month from admission on March 2, 1977.

Just halfway through a short 3-month sentence for theft under $50 and escape, Hudson was considered a minor property offender in an alcohol related pattern of criminal behaviour. For him, alcoholism and delinquency had gone hand in hand from age 17 with only occasional, sporadic work punctuating his involvement with the law. Progressive deterioration with alcohol blackouts, seizures and D.T.'s eventually were compounded with a growing heroin habit which saw him gravitate to Vancouver's skid road and sever ties with wife and family.

An 'old hand' at LMRCC after numerous earlier admissions, Hudson was not showing his usual animosity toward staff on this occasion. (Previous reports showed two attacks against staff during earlier periods of incarceration)

Shortly after admission this time, he was treated for alcohol paranoia and alcohol hallucinosis in LMRCC's Hospital. He was then released after a 10-day treatment and had returned to the West Wing. Prescription medication, chlorpromazine, (an anti-psychotic), had expired a short time before his suicide.

Staff reported that there had been no indications of suicide although he had experienced paranoia and hallucinations prior to hospitalization. Hudson was last checked in his bunk sleeping at 0615 but was discovered hanging in his cell by inmates going to breakfast an hour later.

Key Warnings - Factors for Consideration

1. Even though no stranger to the Correctional Centre nor under any apparent stress, this inmate committed suicide at the beginning of a very short sentence which was certainly not anticipated by staff.

2. Apparent change of affect. Previously combative and obnoxious, this inmate showed fear apparently related to alcohol paranoia.

PROBABILITY OF SUICIDE PER ADMISSION

Rates of suicide in prisons should be looked at from the perspective of the number of individuals entering jails, for each admission is a separate case with a unique probability of suicide.

To compare the Federal Corrections Statistics with our British Columbia data, the following assumptions are made regarding the data of Corrections Service of Canada:

1) The average population over the 6 7/12 years studied in the Federal System was 9600 per year.

2) The average length of stay per admission in the Federal System was 2 years.

3) The number of admissions per year to the Fedeal System was: $\frac{9600}{2}$ = 4800 admissions.

4) The number of admissions for the Federal System over the test period was 4800 x 6 7/12 = 31,598.

B.C. Corrections admission data was collected from the computerized offender data base which has been in operation since 1972. The data from 1970 and 1971 was retrieved from annual reports for the ten year period studied. (Appendix B)

Table 20

Analysis Of Suicide Per Admission Comparison of B.C. Corrections and Corrections Service Canada (25)

B.C. Corrections 1970-1980	# Admissions	# Suicides	Suicides Per 100,000 Admissions
Sentenced Admissions Only	63,400	10	15.7
Remand Admissions Only	37,500	25	66.6
B.C. Corrections * 1970-1980 TOTAL	100,900	35	34.6
Corrections * Service Of Canada 1974-1980	31,600	46	45.6

* Corrections Service Canada test period = 6 7/12 years

B.C. Corrections test period = 10 years

Note: Data normalized by reduction to same base

(per 1000 admissions)

In making observations regarding the foregoing data, one initially notes that there is a significant distinction between Corrections Service Canada and the B.C. Corrections in terms of suicide rates.

> The Federal System in dealing with approximately half the yearly number of admissions compared with the number entering the B.C. Corrections System, shows approximately three times the suicide rate by comparison.

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(25) Data and Analysis provided by Greg Muirhead, Senior Research Officer, B.C. Corrections.

> Obviously the Federal System is dealing with a more serious group of offenders in greater concentration over longer periods of time.
>
> However, we must keep in mind that in dealing with two times the volume of admissions (and one third the suicide rate) we have less opportunity to assess potential suicide candidates at the front end.

One of the clear inferences given the significant difference in suicide rate and the difference in inmate clientele, is the need for different suicide prevention strategies.

The Federal System has a greater opportunity to work over extended periods of time with their potential suicide candidates, indentifying, assisting in coping and insulating these individuals. In the Provincial System, we are faced with the more difficult task of identifying (assessing on admission) these individuals in a much busier and more dynamic system. It would appear, on the surface, that our strategy for suicide prevention should be aimed at the front-end admission process, identifying suicidal inmates and reducing stress where possible to the greatest possible degree.

In examining Table 20 from a purely B.C. Corrections standpoint, we again see the strong discrepancy for remand inmates with a suicide rate four times that of sentenced admissions. Again, clearly the focus of a Suicide Prevention Program must be on the remand inmate.

PART VI

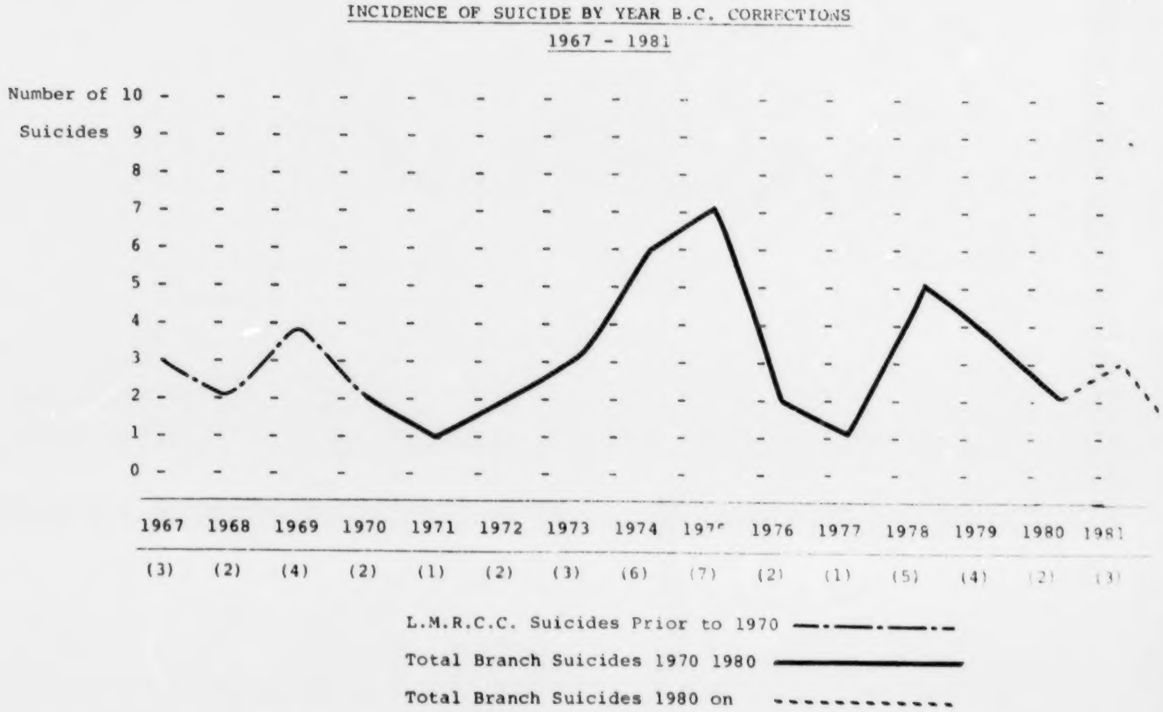
LOGISTICS

INCIDENCE OF SUICIDE BY YEAR

The first step in our examination of suicides in B.C. Correctional Institutions was to consider the occurrance rate over time to determine if there were any patterns, which could be useful in terms of forecasting and prevention.

Figure 10 provides a graphic display of the available data showing a fair degree of fluctuation in the number of suicides over the years in the study period 1970 to 1980.

Figure 10



CONCLUSIONS:

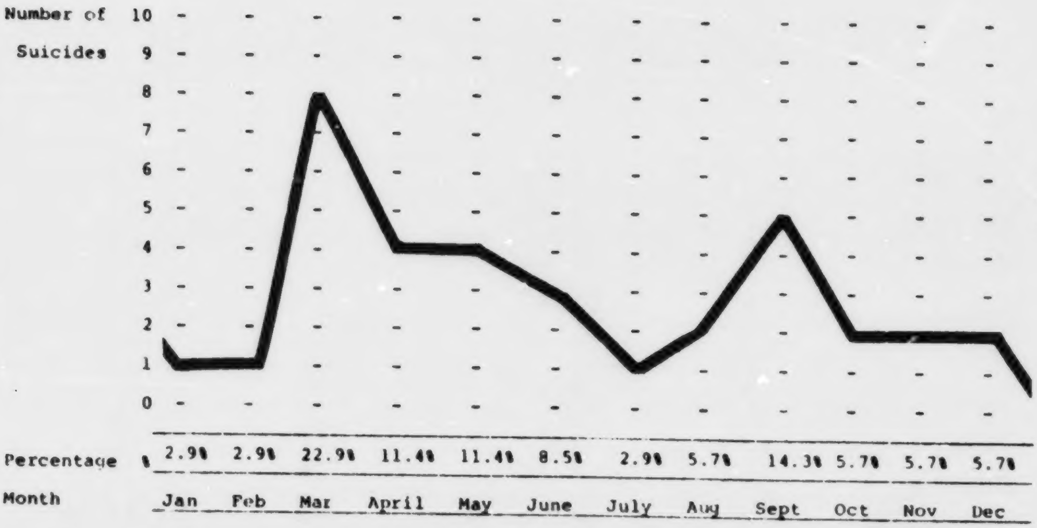
While there is no predictable pattern of the incidence of suicide by year emerging from these figures, it does appear that years of low incidence can be followed by quick increases in absolute numbers with no gradual trends established.

INCIDENCE OF SUICIDE BY MONTH:

When examining the ten year data, 1970 to 1980, in B.C. Corrections, two months of the year appear to have significantly higher proportions of suicide incidents. See Figure 11 showing a peak in March with a minor second peak in the month of September.

Figure 11

INCIDENCE OF SUICIDE B.C. CORRECTIONS BRANCH
BY MONTH OF THE YEAR
1970 - 1980



Higher incidence in these two months may or may not be significant and for better indication, comparisons with other data should prove helpful.

An examination of the American study juxtapose the B.C. Corrections data we do not see a strong correlation on the March peak of suicide incidence; however, March is tied for the third highest rate in the U.S. Our second peak of September matches with the month of highest American jail suicide incidents, and thus shows a signigicant co-relation. (See Table 21)

Table 21

Incidence of Suicides by Month of the Year
Comparison of Two Studies

	B.C. Corrections 1970-80		U.S.A. 1979	
	No.	Percentage	No.	Percentage
January	1	2.9%	28	8.3%
February	1	2.9%	22	6.5%
March	8	22.9% ←	33	9.7% ←
April	4	11.4%	23	6.8%
May	4	11.4%	33	9.7%
June	3	8.5%	40	11.8%
July	1	2.9%	28	8.3%
August	2	5.7%	26	7.7%
September	5	14.3% ←	42	12.4% ←
October	2	5.7%	24	7.1%
November	2	5.7%	21	6.2%
December	2	5.7%	19	5.6%
	35	100.0%	339	100.0%

In terms of explaining the possible dynamics of this pattern, one looks to a variety of precipitating factors analyzed from file information and Coroner's Inquests. In our Branch Study all five September suicides were inmates on remand status before the Court on serious charges, four of them before the Fall Assizes. Four were facing murder trials and one a serious attempted murder/wounding. Trials were just starting or about to start, one victim received an unforeseen delay the day he was to start his trial and committed suicide within hours.

Possible explanations for our high incidence in March is much more difficult to pinpoint, although on a purely subjective level, B.C. Coroner's Service reports March is perhaps the heaviest month for suicides on a province-wide basis. While several faced serious charges on remand and two were awaiting transfer to the penitentiary to serve lengthy sentences, one appears as a non-communicative native escapee, two had serious psychiatric problems, one was 'beside himself' over losing his girlfriend and one appears to have succumbed to alcohol hallucinations. This does not provide any kind of a cohesive explanation for the March high in our suicides.

We must conclude that there are very few generalizations that can be made from this material; however, the one significant correlation that should be utilized is the tie between the September deaths and the fact that these victims were all facing most serious charges in the first days of the Fall Assizes and Preliminary Hearings.

CONCLUSIONS:

Linked to the fact that peaks in our prison suicides occur during the months of March and September, it appears that remand inmates facing serious charges are in high stress situations and bear close staff observation from a suicide potential standpoint.

INCIDENCE OF SUICIDE BY DAY OF THE WEEK:

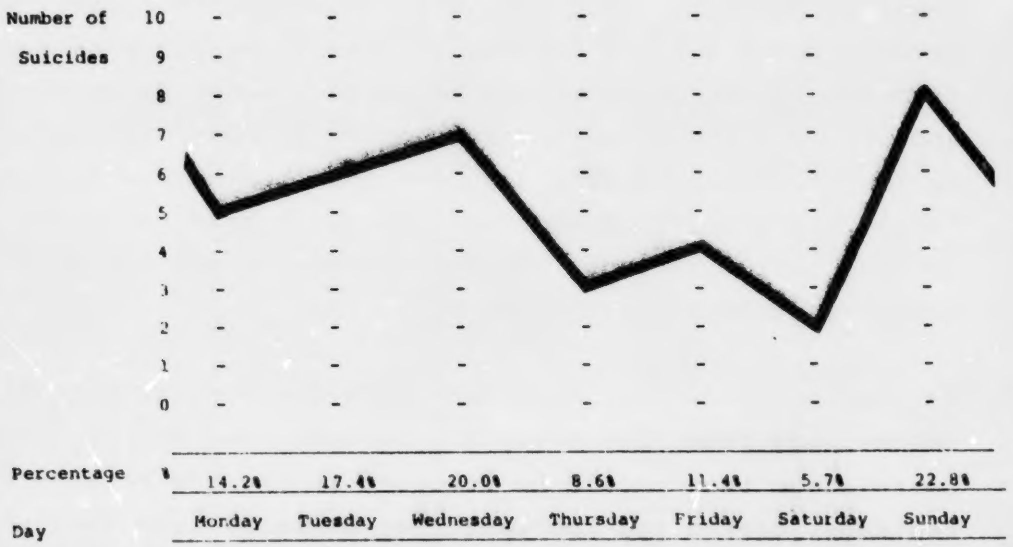
When examining the data from our ten year study in relation to Day of the Week, we see the following distribution Figure 12.

Figure 12

INCIDENCE OF SUICIDE B.C. CORRECTIONS BRANCH

BY DAY OF THE WEEK

1970 - 1980



There appears to be a gradual increase in suicides from Monday, (14.2%) leading to Wednesday's secondary peak of 20% of total suicides. The incidence then drops sharply, climbing again on Sunday to the high of 22.8% for the week.

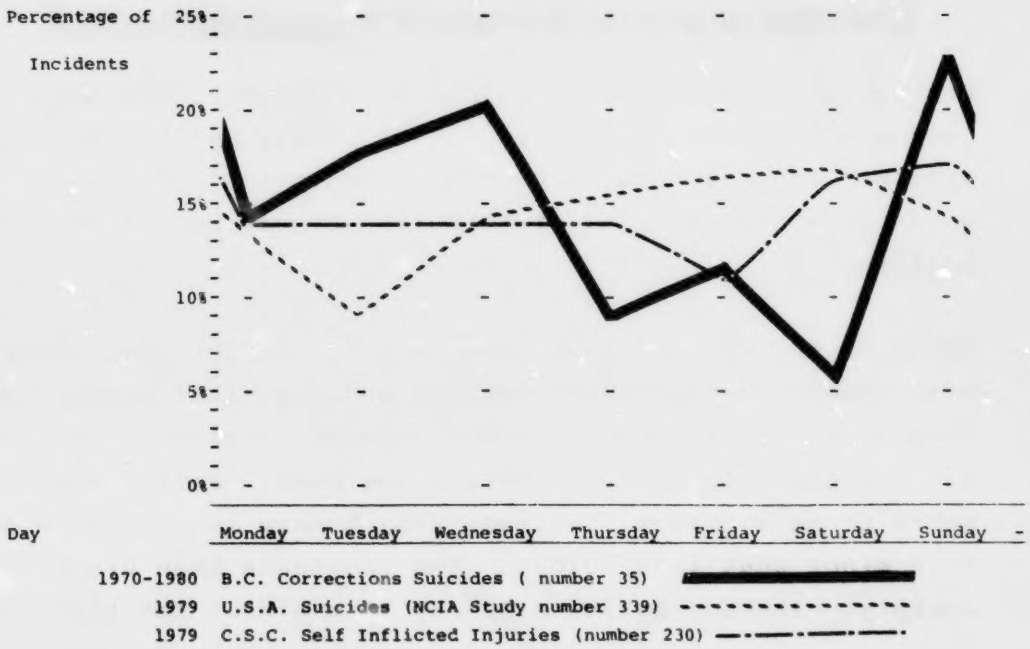
Before speculating on the dynamics of our profile it would seem advisable to compare our data with other available studies to determine similarities and differences.

Comparison with the 1979 U.S. Study of 339 suicides and the 1979 Correction Service of Canada research into 230 self-inflicted injuries relative to day of occurance shows one important common factor. There appears to be an elevated level of incidents on weekends in all three studies. See Figure 13.

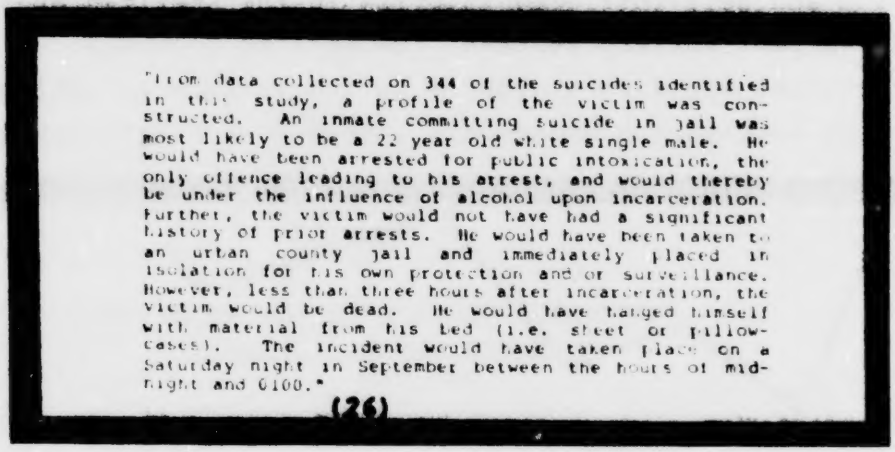
While Saturday and Sunday are both heavy days in terms of suicide and self-inflicted injuries in the American and Canadian penitentiary systems, the British Columbia Correctional experience appears on the surface to reflect highs on Sundays and Wednesdays with a low on Saturdays.

Figure 13

COMPARISON OF SUICIDES AND SELF-INFLICTED INJURIES IN THREE JURISDICTIONS BY DAY OF THE WEEK



It is clearly evident that self-inflicted injuries in Correction Service Canada are elevated on weekends (when activities are at a minimum) and taper off during week days. The American study on jail suicides notes a heavy incidence of suicides among younger detainees who are brought in Friday and Saturdays for public intoxication and drinking related offences. The following hypothetical construct provided in the executive summary of the U.S. report puts this in the following perspective: (26)



"From data collected on 344 of the suicides identified in this study, a profile of the victim was constructed. An inmate committing suicide in jail was most likely to be a 22 year old white single male. He would have been arrested for public intoxication, the only offence leading to his arrest, and would thereby be under the influence of alcohol upon incarceration. Further, the victim would not have had a significant history of prior arrests. He would have been taken to an urban county jail and immediately placed in isolation for his own protection and/or surveillance. However, less than three hours after incarceration, the victim would be dead. He would have hanged himself with material from his bed (i.e. sheet or pillowcases). The incident would have taken place on a Saturday night in September between the hours of midnight and 0100."

(26)

Perhaps an examination of suicides in R.C.M.P. and Sheriff's lock-ups in British Columbia, where Friday and Saturday admissions associated with alcohol consumption are elevated, would show a profile of distribution closer to the American pattern.

Again on the surface from data in B.C. Corrections, where we have fewer off-the-street entries and a greater number of inmates who have already passed through local lock-ups, we see two peaks in suicides during the week. First, there appears to be a gradual increase from Monday leading to Wednesdays minor peak in suicides. The incidence then drops sharply, climbing again on Sunday to the high for the week.

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(26) NCIA, Darkness Closes In, p. ii.

The key for B.C. Corrections is of course the fact that with such a small "n" (study sample) there is no one day that is significant from a statistical standpoint as far as suicides are concerned.

Therefore, it is difficult to speculate on the dynamics behind our profile, or the possible causes for the two peaks. They could be associated with visits or lack of visits on Sundays, concern over expected developments in Court during the coming week, transfers or other upsetting expectations. As with some other factors, there is no time that we could say we are not vulnerable and there is no substitute for constant surveillance from a suicide prevention standpoint.

CONCLUSIONS:

While the study showed Wednesdays and Sundays had higher incidences of suicides in B.C. Corrections, staff should be aware that there are really no safe days where suicide vigilance could be relaxed.

INCIDENCE OF SUICIDE BY TIME OF THE DAY:

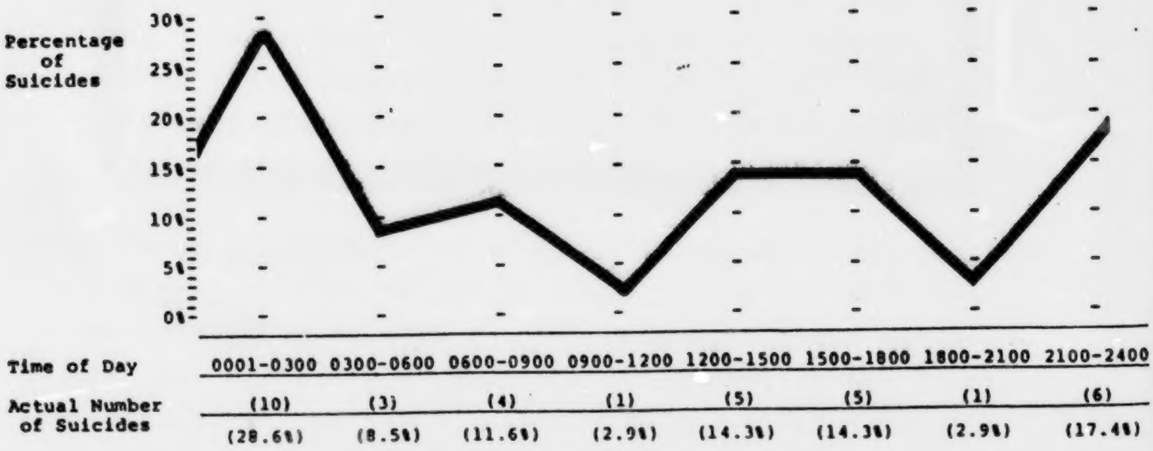
Previous suicide studies involving prisons conclude that the incidence of suicide is greatest between midnight and morning shift change, during which time staff supervision is at its lowest. It would appear that in the B.C. Correctional System our greatest incidence is between midnight and 3:00 a.m., (See Figure 14), which is in line with other data mentioned.

Figure 14

INCIDENCE OF SUICIDES B.C. CORRECTIONS BRANCH

BY TIME OF DAY

1970 - 1980

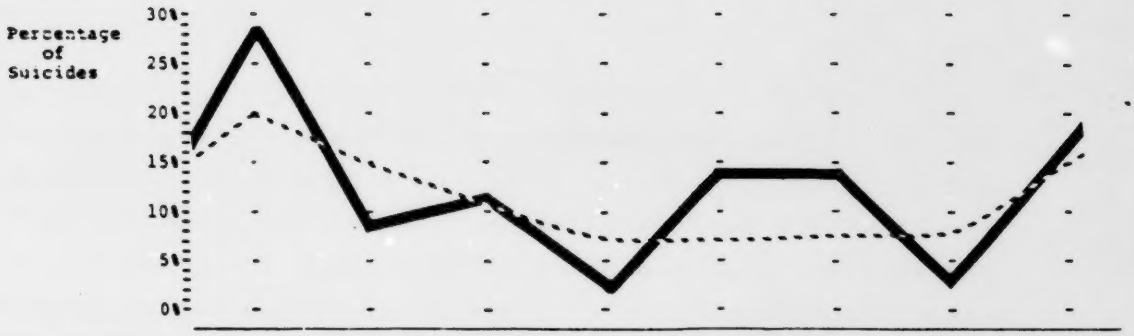


While the Federal Corrections Study did not examine suicides in relation to time, we were able to compare our data with the American study on jail suicides conducted by N.I.A.C. in 1979. Figure 15 shows a remarkable similarity in the three-hour patterning of suicide occurances with highest incidence in both between midnight and 3:00 a.m. Both depict a decline in the morning hours until noon when there is a leveling off, low in the American study for the rest of the afternoon. Our B.C. figures would indicate a gradual rise in the afternoon, leveling off before a fall in incidence during the after-dinner hours. Like the U.S. Study there is then a sharp increase during the late evening until the daily high is reached after midnight.

Figure 15

INCIDENCE OF SUICIDES BY TIME OF DAY

COMPARISON OF TWO STUDIES



Time of Day	0001-0300	0300-0600	0600-0900	0900-1200	1200-1500	1500-1800	1800-2100	2100-2400
Actual Number of Suicides B.C. Study	(10)	(3)	(4)	(1)	(5)	(5)	(1)	(6)
	(28.6%)	(8.5%)	(11.6%)	(2.9%)	(14.3%)	(14.3%)	(2.9%)	(17.4%)
Actual Number of Suicides U.S. Study	(65)	(48)	(36)	(23)	(23)	(40)	(41)	(49)
	(20%)	(14.8%)	(11.1%)	(7.1%)	(7.1%)	(12.3%)	(12.6%)	(15%)

B.C Corrections Study 1970-1980 ▬▬▬

N.C.I.A. Study U.S.A. 1979 (only) - - - - - - - - - - -

In attempting to explain the dynamics behind this patterning, we draw only suggested explanations. Certainly the greatest incidence takes place between midnight and 0300 in both systems. These findings would tend to support the hypothesis that suicides are apt to occur during times of inactivity and when staff are at the lowest complement, generally at night. From a staffing perspective, it would appear that increased coverage during this period 0001 and 0300 would be the most effective time for deployment for suicide prevention.

The question is raised relative to the time of day in which attempts occur. In that the data is not presently available for over the 10 year period, we may be interested in focusing on this aspect to determine the success of our intervention techniques and in relation to time of day .

CONCLUSIONS:

Because of the high incidence of suicides in the late evening and early morning hours, following midnight, it would seem important for staff members on these shifts to be watching for suicide clues and maintaining regular (or staggered) close visual checks of all inmates as frequently as possible.

Inmates previously identified as upset or suicidal should be subject to the closest supervision possible during these time periods; with use of observation cells or moving the inmate to cells in closest proximity to the officer's station or within constant visual contact.

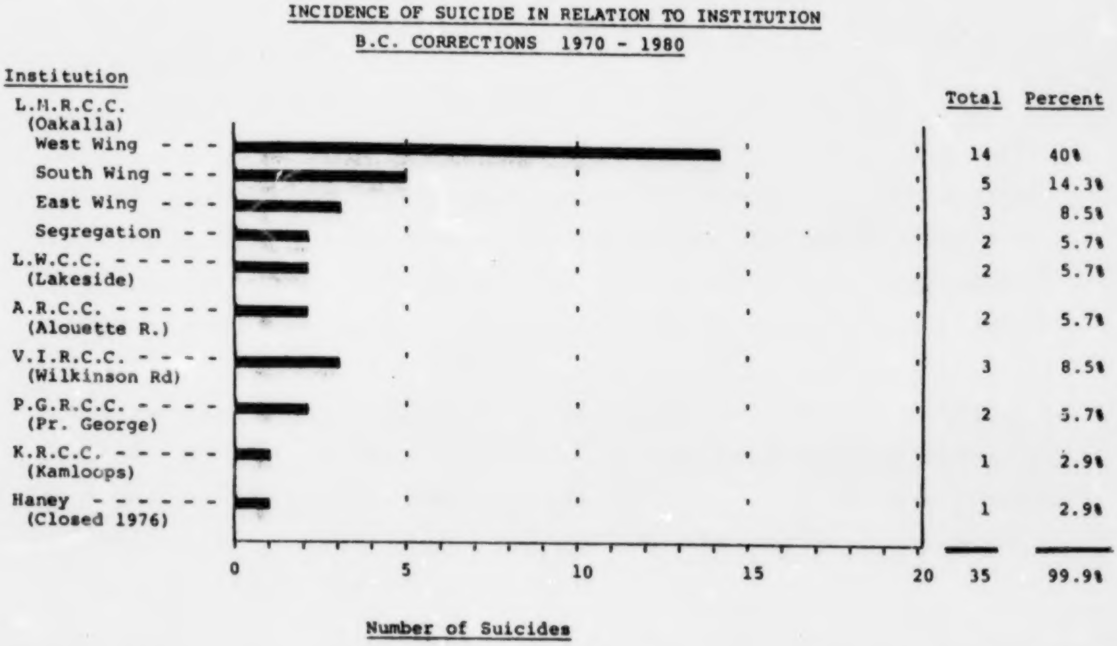
When considering staff deployment in relation to suicide prevention, we would see the best time for increased coverage to be 0001 to 0300 hours. Alternatively, checks (counts) should be stepped up between 11 p.m. and 4 a.m.

There appears no "safe time of day from a suicide prevention standpoint, and thus constant vigilance is the best rule to follow.

INCIDENCE OF SUICIDE BY INSTITUTION:

One of the most important factors to consider is the incidence of suicide in relation to the actual institutional facilities in which we house prisoners. As mentioned earlier in this report, several facilities have opened and some have closed during the ten year study period; however, the Branch records and inquiries at each institution provided a reliable count of suicides. Figure 16 depicts the institutional incidents with percentage of total suicides over the ten year study period.

Figure 16



By way of clarification, we have counted and identified the institution or unit where the suicide attempt occured. In the few cases where the victim was moved and later died elsewhere, e.g. in hospital, or similarly, where the victim was found adjacent to the institution where he was believed to have escaped from, the case was counted in our research as an inmate suicide. The cases of those who suicided on recapture following escapes or cases on remand in jail or lock-up facilities not under the care and control of B.C. Corrections Branch were not counted in this research. (A rough estimate of the victims in the latter categories total less than 5 during the ten year period under consideration.)

Several important observations are immediately evident from this data:

a) There have been no suicides in Juvenile Detention Units.
b) There have been no suicides in minimum security Forest Camps.
c) The only suicides in a facility, other than a maximum security installation, have been for a facility specializing in the custody of the alcoholic offender (A.R.C.C.).

As in the case of self-inflicted injuries, the incidence of suicide appears to occur or not occur in direct relation to the degree of security in institutions. Years of experience have reinforced the principle that minimum security settings do not experience the incidence of self-inflicted injuries except in the rarest of cases and suicides in minimum camps or similar settings are almost unheard of. Staff will simply explain that if pressures or anxieties arise, an inmate in minimum security may show symptoms of social withdrawal, or ultimately escape, rather than inflict self-injury or attempt suicide.

CONCLUSIONS:

Suicide prevention programs would more effectively apply to maximum security facilities particularly focusing on areas of the institution housing remand prisoners.

Staff training in suicide prevention should be properly focused on staff employed in maximum security Correctional Centres even though all staff should have an understanding of the dynamics of suicide, prevention techniques, and the warning signs of suicide.

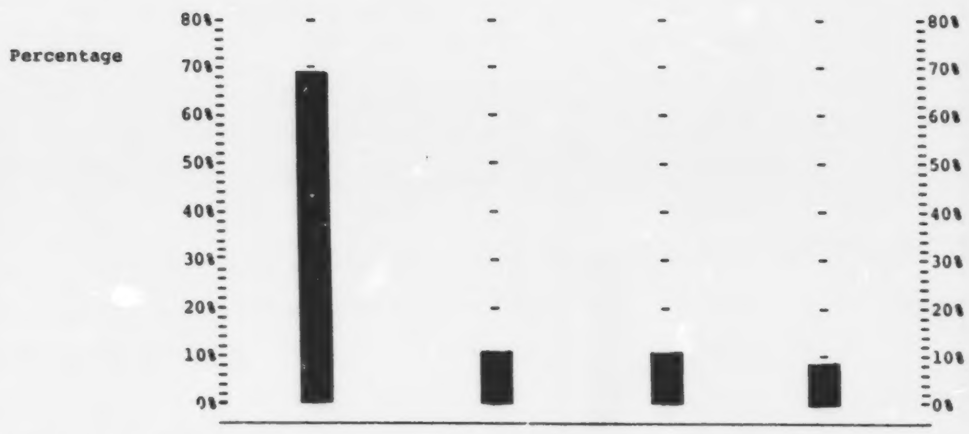
INCIDENCE OF SUICIDE IN RELATION TO TYPE OF CELL

Having considered the incidence of suicide over the 10 year period by the Correctional Centre in which they occur, we now consider the factor, 'type of cell' in which the victim was confined. In this regard the important aspect is the degree of security/surveillance of the cell or area of confinement.

As a brief overview, we see that almost 70% of sucides were committed by individuals in general population cells (see Figure 17).

Figure 17

INCIDENCE OF SUICIDES B.C. CORRECTIONS
BY TYPE OF CELL
1970 - 1980

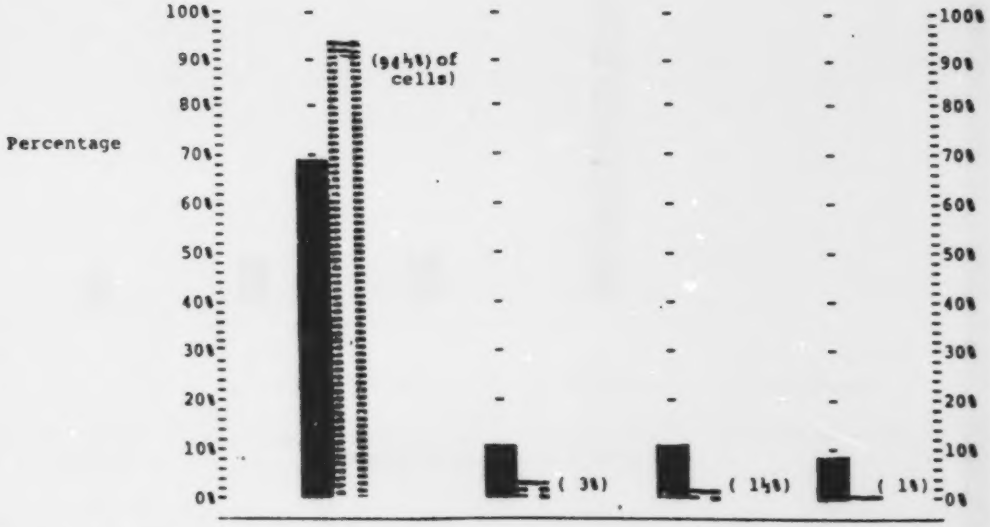


Number of Suicides	24	4	4	3
Percentage	68.6%	11.4%	11.4%	8.6%
Type of Cell	General Population	Segregation (Punishment)	Observation	Protective Custody

The real relevance of suicides by type of confinement is brought into focus with an awareness of the number (or proportion) of the inmate population housed in a particular type of cell or security classification. With this knowledge we are then able to look at proportions of suicide for types of cell area and determine if one area or another has a higher or lower potential for suicides. Unfortunately, statistics were not gathered over ten years on the number of inmates actually housed in certain types of cells. However, in an effort to yield an accurate approximation, Branch cell capacity numbers by type of cell were utilized. Figure 18 shows approximately 95% of our cells in B.C. Institutions are classified "general population" which includes hospital beds. As indicated earlier, this is where the majority of our suicides occur.

Figure 18

INCIDENCE OF SUICIDES B.C. CORRECTIONS
BY TYPE OF CELL
1970 - 1980
(Showing current cell capacity)



Type of Cell	General Population	Segregation (Punishment)	Observation	Protective Custody
Number of Suicides	24	4	4	3
Percentage	68.6%	11.4%	11.4%	8.6%

Suicides - - ▬ Cell Capacity in Percentage - - ▥

Put in perspective, we must recognize the fact that not all cells designated "general population" are in fact utilized all the time for "general population" inmates. We know for example that "protective custody" inmates could be housed in the east Wing of L.M.R.C.C. or in "hospital" beds in several of our institutions in the system. Given that, the above facts may limit the accuracy of generalizations concerning the type of cell in relation to suicide, several observations are still in order:

a) The majority of suicides occur in general cells;
b) We see that a total of 30% of our suicides occur in the segregation, observation and protective custody cells which combined, amount to only 5.5% of our cell capacity; and
c) In proportion, the protective custody suicide rate would seem to be by far the highest followed by Observation areas.
d) Protective custody and observation areas must be considered high risk from a staffing and suicide prevention training standpoint.

In comparing our data with other jurisdictions and in particular with the Penitentiary Study, reference is made to Table 22:(next page)

Table 22

COMPARISON OF SUICIDES BY TYPE OF CELL

B. C. CORRECTIONS AND CORRECTION SERVICE CANADA

Type of Cell	B.C. Corrections 1970-1980			
	Population		Suicides	
Segregation	TOTAL POPULATION DISTRIBUTION UNKNOWN	3%	4	11.4%
Special Handling Unit (Area)		1.5%	.4	11.4%
Protective Custody		1%	3	8.6%
General Cells & Elsewhere		94.5%	24	68.6%
Totals		100%	35	100%

Type of Cell	Corrections Service Canada 1974 - 1980			
	Population		Suicides	
Segregation	294	4%	9	20%
Special Handling Unit (Area)	76	1%	0	0%
Protective Custody	771	10%	12	26%
General Cells & Elsewhere	6630	85%	25	54%
Totals	7771	100%	46	100%

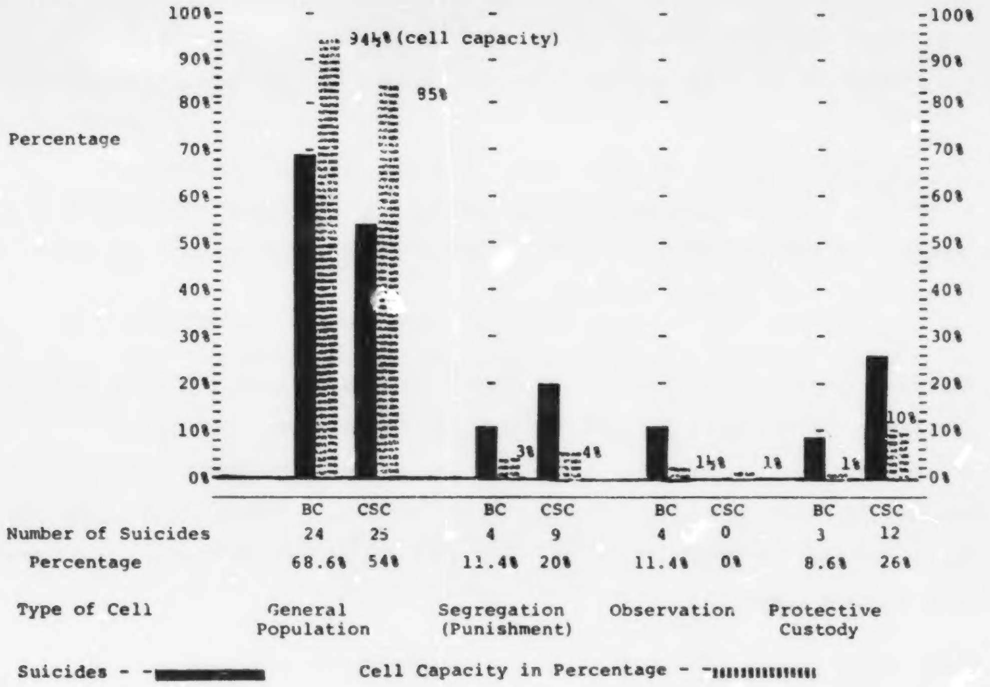
It would appear that in Corrections Service Canada, 54% of suicides take place in general population cells which account for 85% of the housing of inmate population. Of the remainder, 26% of suicides take place in protective custody cells which account for only 10% of inmate housing. The highest rate per area for suicides in the federal system occurs in the segregation areas where 20% of suicides occur among 4% of the inmate population.(See Figure 19).

Figure 19

INCIDENCE OF SUICIDE BY TYPE OF CELL

B.C. CORRECTIONS AND CORRECTIONS SERVICE CANADA

(Showing proportion by cell capacity)



By way of comparison, both systems show that by far the greatest majority of suicides are in general cells and very roughly in the same proportion. For C.S.C., their observation and general population cells have the lowest rates of suicide followed by protective custody with the highest rate in segregation. For B.C. Corrections the highest rate is in protective custody followed by observation segregation and a low in general population.

CONCLUSIONS:

In regard to type of cell, protective custody, observation and segregation areas have the highest suicide rates in proportion to the number of inmates housed in these areas.

The higher rates of suicide in protective custody, observation and segregation units, increases the need for better surveillance, careful staff selection and staff training for these areas.

Having noted the higher "rates" for suicide in protective custody observation and segregation areas, we are still faced with the fact that by far the greatest "number" of suicides occur in the general population cells. Thus, suicide can and will occur in any area of the institution making vigilance in all areas important.

INCIDENCE OF SUICIDE BY METHOD

Hanging is considered the most common method of institutional suicide according to the majority of previous studies. Our findings are consistent as shown in the following: (Table 23)

Table 23

Incidence Of Suicides By Method
B.C. Corrections 1970-80

Method	No.	Percentage
Hanging	29	82.8%
Slashing	2	5.7%
Strangulation	1	2.8%
Jumping	1	2.8%
Fire	1	2.8%
Drug Overdose	1	2.8%
Total	35	100%

From the American Study and our own Canadian Federal Corrections Service these ratios are roughly duplicated. (Table 24)

Table 24

Comparison of Suicides by Method
Three Jurisdictions

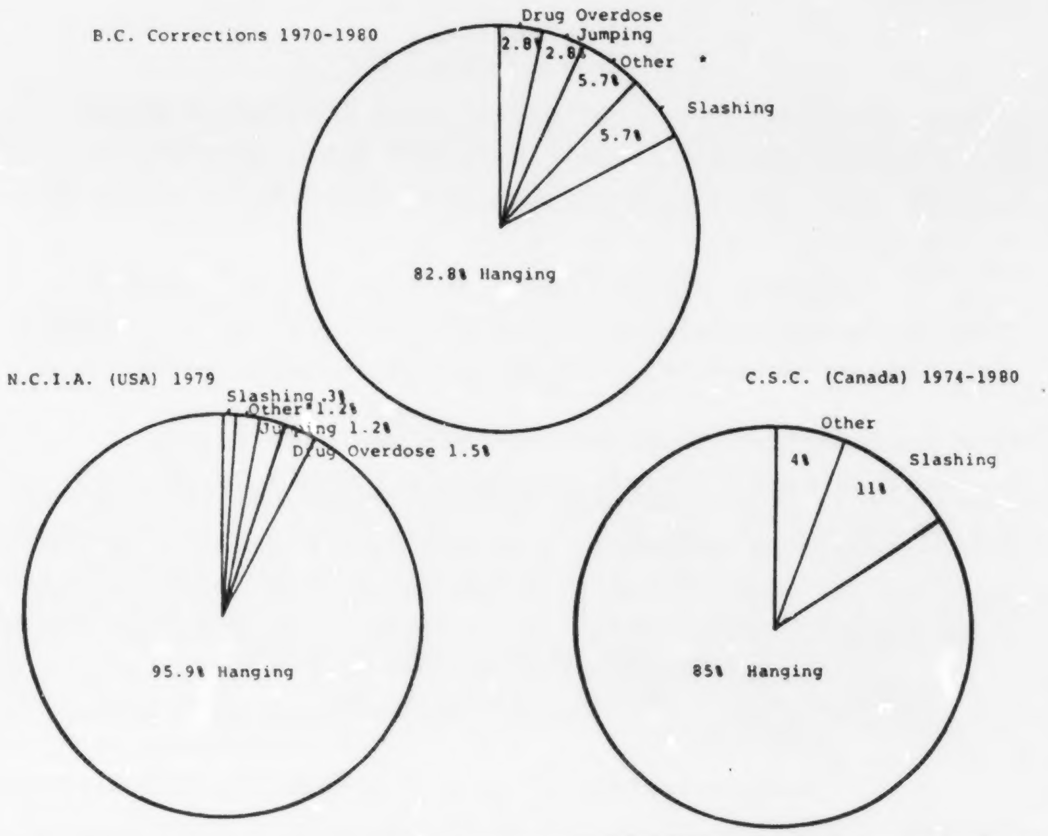
	B.C.Corrections 1970-80		N.C.I.A.(USA) 1979		C.S.C.(Fed-Can) 1974-78	
	No.	%	No.	%	No.	%
Hanging	29	82.8%	329	95.9%	39	85%
Slashing	2	5.7%	1	.3%	5	11%
Drug Overdose	1	2.8%	5	1.5%	Nil	Nil
Jumping	1	2.8%	4	1.2%	Nil	Nil
Other*	2	5.7%	4	1.2%	2	4%
Total	35	99.8%	343	100.1%	46	100%

*OTHER, includes: Fire, strangulation, shooting, electrocution etc.

Displaying this data more graphically, refer to Figure 20.

Figure 20

COMPARISON OF SUICIDE BY METHOD
IN THREE JURISDICTIONAL STUDIES



The clear conclusion is that hanging is the most often utilized suicide procedure. This is perhaps related to lethality (lack of oxygen to the brain can be fatal within two minutes), and simplicity of execution (almost any material, clothing or bedding can be employed to effect a noose and once the weight of the body tightens the noose, it is difficult if not impossible to reverse the procedure).

Given the fact that successful suicides are most often effected by hanging, we should now examine the matter of implements used with an aim of considering intervention by restricting implements used by inmates who are suicidal.

In examining implements used and the logistics of our suicides, focus is placed on hanging due to the fact that by far the greatest majority of suicides fall in this category.

Table 25

Incidence of Suicide by Implement Used and Logistics
B.C. Corrections 1970-1980

Method	Implement Used	No	%	Logistics	No	%
Hanging	sheets	16	45.7%	Door bars	16	45.7%
	clothing	8	22.8%	Front bars	3	8.5%
	blankets	2	5.7%	Ceiling bars	4	11.4%
	towels	2	5.7%	Window bars	1	2.9%
	chain(bed)	1	2.9%	Bed support	3	8.5%
	subtotal	(29)	(82.8%)	Light fix.	1	2.9%
				Off grounds	1	2.9%
					(29)	(82.8%)
Slashing	razor blades	2	5.7%	Wrists/ throat	2	5.7%
Strangulation	towel	1	2.9%	Neck tourniquet	1	2.9%
Jumping	N/A	1	2.9%	Climb wire mesh	1	2.9%
Fire	Matches/ Lighter	1	2.9%	Cell contents	1	2.9%
Drug Overdose	Medication	1	2.9%	Hoarding Med.	1	2.9%
		35	100%		35	100%

In terms of comparing our data with other jurisdictions on this factor we find the figures in the American Study close to ours. (Table 26) The Canadian Correctional study of Federal Penitentiaries while examining method, did not review implements used or logistics in their published report.

Table 26

Incidence of Suicides by Implement Used
Comparison Of Two Studies

	B.C. Corrections 1970-1980			U.S. (NCIA) Study 1979	
Implement Used	No.	Percentage		No.	Percentage
sheets/bedding	18	51.4%		144	43.6%
clothing	8	22.9%		105	31.8%
	-	-	belt	28	8.5%
	-	-	laces	11	3.3%
towels	3	8.5%		16	4.8%
	-	-	rope	1	.3%
razor blades	2	5.7%		1	.3%
fire	1	2.9%		-	-
jumping	1	2.9%		-	-
drug overdose	1	2.9%		5	1.5%
other (chain)	1	2.9%	other	19	5.8%
TOTALS	35	100.1%		330	99.9%

By combining the categories of bedding, clothing and towels, the comparison totals account for 82.8% of the implements used in B.C. suicides and 92% of American suicides studied.

While it is tempting to over-simplify conclusions and plan prevention strategies based on this knowledge, we can only say that we are hereby made aware that hanging with bedding or clothing is the most likely material a suicidal inmate will use in attempting to "Top himself".

Merely covering exposed bars, installing T.V. monitors, supplying "tear-away clothing/bedding", or using "strip" cells for suicidal inmates is no guarantee of prevention.

For a determined suicider, he or she will simply turn to another method. The case of the inmate who accomplished his end by choking himself on toilet paper attests to this fact and the ingenious means that can and may be employed by determined individuals.

Being careful not to look to "Cosmetic precautions", Burtch and Erickson stated:

> "Recommendations for more vigorous cell searches to uncover dangerous weapons and improved screening methods to intercept potentially lethal contraband materials ... would, if implemented, probably have little effect upon the incidence of prisoner's suicide". (27)

While stating this fact, we do not wish to perpetuate the old prison cliche, "We did everything we could....If someone really wants to kill himself, they'll eventually find a way." There is no substitute for the human interaction between staff and inmate. As noted in the American Study:

> "Attention should rather be directed not toward trying to outwit the potential suicide victim, but toward diverting the potential victim to much needed alternative services, e.g., mental health, counselling, other programs or detoxification."(28)

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(27) Burtch & Ericson, The Silent System, pp. 72-73.

(28) NCIA, Darkness Closes In, p. 32.

CONCLUSION

In attempting to divert the suicidal inmate, less attention should be paid to physically restricting him from suicide by removal of all potential suicide implements and more attention should be paid to providing essential human interaction with staff, or other inmates to hopefully provide alternative solutions and services.

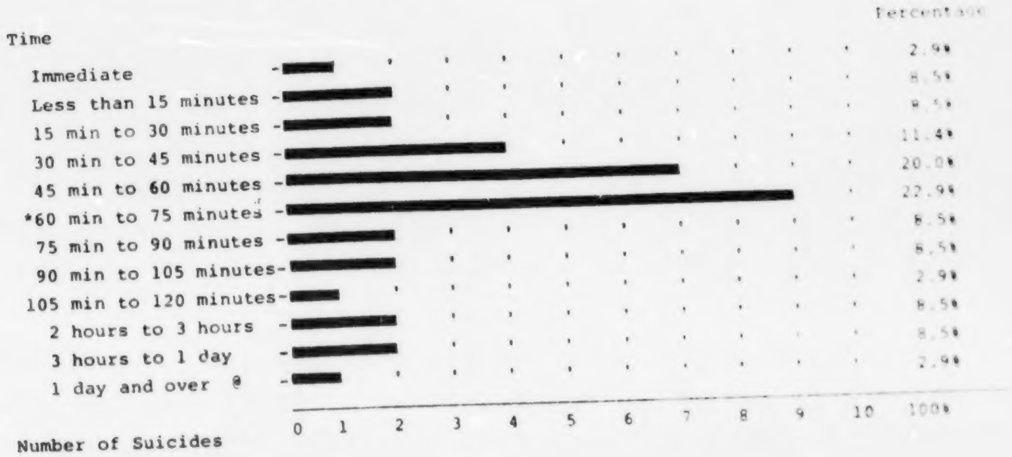
INCIDENCE OF SUICIDE BY TIME LAPSE

Consideration of the amount of time that lapses between when the inmate victim was last checked or seen alive and when his suicide is discovered, can be an important factor in planning a suicide prevention program.

Our basic data reveals a pattern of distrubution with the greatest number of cases found just over an hour and the second greatest number found between 45 min. and one hour from last check. (Figure 21)

Figure 21

INCIDENCE OF SUICIDE B.C. CORRECTIONS
BY TIME LAPSE FROM LAST CHECK
UNTIL DISCOVERY
1970 - 1980



* Note One hour rounds are the accepted standard

@ Note One victim was declared AWOL and later found off the Grounds A.R.C.C.

Our next point of concern was an examination of average time till discovery for each institution or unit in which suicides have occurred. As a note of explanation, several cases were excluded from the averaging process due to unusual circumstances.

Excluded were two cases at A.R.C.C. and one at V.I.R.C.C. In the A.R.C.C. cases, both victims were thought to have escaped and were in fact found off the grounds, one 9 hours later during daylight and one 5 days later. The case of a victim jumping at V.I.R.C.C. where staff were on the scene actively trying to get the victim down, is not included either as there was no question of time lapse.

Included in the sample, (fairly or unfairly) are the cases of 3 victims who were believed by officers to be sleeping in their bunks. One was discovered in the morning, 6 hours after being last seen "up and around" in L.M.R.C.C.'s East Wing. Another victim, also apparently asleep, was found 3 hours after the last "live" check at V.I.R.C.C. Finally one L.M.R.C.C. South Wing inmate, sleeping after overdosing on medication, was discovered 2 hours and 10 min. after he was last heard snoring.

Using the base of 32 cases including the above mentioned "sleeping" cases, we count a total of 2,217 minutes or an average of 69 minutes between last check until discovery. However, omitting the unusual delays of those three cases, we calculate a total of 1,547 minutes or a 53 minutes average. As can be readily seen, one average works out to slightly over the hourly check while the other comes out just under an hour from last live check till the suicide victim was found.

To examine this factor by institution, refer to Table (27).

Table 27

Incidence of Suicide By Institution,
Time Lapse Till Discovery
B.C. Corrections 1970-1980

No. of Institution	No. Of Suicides	Average No. Minutes	Of Minutes
LMRCC			
West Wing	14	810 min.	58 min.
*East Wing	2	156 min.	78 min.
*South Wing	4	226 min.	56 min.
Segregation	2	110 min.	55 min.
LWCC	2	75 min.	37 min.
**VIRCC	1	95 min.	95 min.
KRCC	1	35 min.	35 min.
PGRCC	2	100 min.	50 min.
*ARCC	N/A		
HANEY(now closed)	1	20 min.	20 min.
TOTAL	29	1,627 min.	56 min.

*Not Including:
2 cases of escape
3 cases of apparent sleeping
1 case of jumping

It is interesting to note that the average time lapse in finding a victim is in fact the maximum time allowed for making security checks. In other words, 50% of the suicide cases were over the normal hour allowed in making security rounds.

It would appear the problems of discovering suicide attempts are directly linked to staff surveilance and control. The determined attempter, choosing a highly lethal method such as hanging, combined with timing his attempt between rounds can further overcome discovery and rescue by disguising the situation. Staff making rounds have been fooled in several instances by inmates arranging their attempts to appear as if they were sleeping, e.g. tying up to chains on bunk beds.

The importance of conducting frequent "live" counts is underlined. It may appear contradictory that we are looking for more frequent checks of inmates particularly potential suicide cases and at the same time are asking staff to take a little longer and more care in checking inmates. Perhaps it would be possible to obtain electronic surveillance (parabolic microphone) equipment which could be utilized by a Correctional Officer to detect breathing (or lack thereof) as he checked individual cells on night rounds.

With regard to time lapse vis-a-vis shift times, see Table 28

Table 28

Incidence Of Suicide By
Time Lapse Till Discovery Per Shift
B.C. Corrections 1970-1980

Time	No. Of Suicides		Total No. Of Minutes Till Discovery		Average Minutes Till Discovery
2400 - 0400	9		495 min.		55 min.
0400 - 0800	4		290 min.		72 min.
0800 - 1200	2		100 min.		50 min.
1200 - 1600	6		407 min.		68 min.
1600 - 2000	4		101 min.		25 min.
2000 - 2400	4		234 min.		58 min.
Total	29	Total	1627 min.	Average	56 min.

As might be expected, the early morning shift, when staff numbers are lower, shows the greatest time lapse before discovery. One would have thought by the same token, that midnight to 0400 would also be very high. It is also somewhat surprising that early afternoon is a period when discovery takes longer while the shortest time for discovery is 4 p.m. to 10 p.m.

Related to the matter of time lapse till discovery, is the issue of who is making the discovery. In 7 cases inmates either found or alerted staff to the suicide attempt and in many cases they were of great assistance in attempts to rescue the victim.

On the other hand, in one case a cellmate knowing the victim was going to attempt suicide, woke up during the "successful" attempt, but did nothing to assist and did not alert the staff.

In another case at V.I.R.C.C., inmates in unison called for the victim to jump while staff struggled to talk him down and move mattresses into position to neutralize the attempt.

CONCLUSIONS:

Lapse time between the last "live" check by a staff member and discovery of the inmate victim averages close to an hour. With an hour being the mandatory standard for checking inmates in secure institutions, we conclude that an effective suicide prevention technique would be to increase the frequency and perhaps the quality of checks.

Perhaps electronic sensing devices may assist Correctional Officers in some instances in determining the difference between a sleeping inmate and one who is attempting suicide.

Clearly, an inmate displaying any danger signs from a suicide point of view, should be subjected to much closer surveillance.

It is possible other inmates can be a positive resource in suicide prevention; however, proper understanding on the part of staff and proper selection of inmates are essential.

CORONER'S INQUEST RECOMMENDATIONS

Over the ten year period, Coroner's Inquests were held in Prince George, Kamloops, Maple Ridge, Victoria, Burnaby and New Westminster in proximity to the Correctional Centres where the deaths occurred.

After ironing out some initial difficulties in identifying all of our cases for retrieval of Inquest Reports, (some victims were registered originally in B.C. Correction records under aliases) we were able to compile the following list of findings and recommendations:

> In 27 cases, 89 recommendations were made, most of which were addressed to the Corrections Branch;
>
> In 8 cases, no recommendations were made;
>
> In 22 cases, no blame was attached to staff or institution;
>
> In 8 cases, Coroner's Inquests were silent on the issue of blame;
>
> In 5 cases, fault was found or comments were made alluding to negligence on the part of the Correctional Branch or its staff members.

Findings of Fault or Negligence

In the 5 cases in which fault was found, the Coroner's Juries identified problems in four while the Division of Inspection and Standards raised issues in one additional case. In several cases, there were joint findings with both the Division and the Coroner's investigation commenting on deficiencies in service delivery or safety.

In the death of a Haney trainee the Coroner's Jury called for the appointment of a full time psychiatrist and admonished the institution for not transferring the victim who had two prior suicide attempts (immediately before his successful attempt) to an outside mental institution as Haney staff were judged, in the Juries' eyes, unqualified to handle the situation.

While there is no record of response taken regarding those specific recommendations the Branch was certainly sensitized to the need to refer for outside psychiatric help or hospitalization in cases such as this. Haney closed three years later.

Irregularities in taking the physical count (checking inmates), signing over at the beginning of shift and shift officers taking care to read the tier log for possible alerts were matters raised in two other LMRCC Inquests.

After a cell fire suicide at VIRCC, a Coroner's Jury fully endorsed the Fire Marshall's Report calling for:

1) The removal of alkyd paint at VIRCC and other Correctional Centres throughout our system and replacement with fire retardant paint

2) Installation of smoke detectors with proper alarms and annunciator panels in the operations area as ordered at VIRCC and throughout B.C.'s Correctional system.

3) Liaison with community fire officials for simultaneous reporting of further fires,

4) Training staff in the use of breathing apparatus, and

5) Examination of the master key system for speeding access to cell areas in cases of emergency.

While commending the staff and inmates for conscientious action in fighting this fire it was the juries "opinion that the operators of the prison (Corrections Branch or B.C. Buildings Corporation) were negligent in not ensuring that its emergency fire fighting equipment (hose and extinguishers) were adequate" although they concluded, "Proper fire fighting equipment could not have saved life in this instance".

Moving beyond the fire recommendations, serious questions concerning surveillance and control were raised when it was realized that the victim had managed to mount a successful suicide fire within hours of an earlier fire and slashing attempt. Some of these questions remain unanswered.

In two cases, one at P.G.R.C.C., resuscitation attempts were not continued until the arrival of qualified medical officials.

Experienced personnel, in one case an ambulance team, had worked unsuccessfully for over 15 minutes to revive the victim without results; however, the rule is that the decision to cease life saving attempts must rest with a qualified medical person. Normally the victim is 'officially declared' after a physician's examination and the decision to cease resuscitation efforts.

In a much earlier V.I.R.C.C. suicide, an inmate jumped to his death after climbing a wire tier screen. Depressed and experiencing drug flashbacks the victim had been known to the part time institutional Doctor who was uneware that the victim had been readmitted. Knowing about this inmate's psychiatric-problems the doctor, on only sessional contract, felt he could have been of assistance had he known the individual was back inside. The Doctor's written submission to the inquest was no doubt reflected in the Juries' recommendations for the establishment of psychiatric personnel and facilities to be available to the inmates at all times. In response to this finding and in the recognition of a real need, the medical parades at V.I.R.C.C. were doubled with twice weekly visits by the Medical Officer and closer liaison established with local psychiatric facilities.

While not raised at a Coroner's Inquest, the matter of ensuring officers making rounds were checking "live" persons was brought to the fore in three other cases when the victims were thought to be sleeping. Similarly, in dealing with staff routine and security procedures it was noted in one of the A.R.C.C.suicides where the victim was declared A.W.O.L., the quality of the search of surrounding grounds was initially brought into question. The victim, who was believed to have escaped was found 5 days later several hundred yards from the facility in a wooded area. A "search" of grounds and surroundings had been conducted without success the morning after the victim had been declared A.W.O.L.

We now turn to the 27 cases in which no fault was found but Coroner's Juries made recommendations for improvements.

In each case where Coroner's Inquests have generated recommendations, these recommendations have been forwarded to the Attorney General's Office where they are then recorded and sent to the Commissioner of Corrections for consideration. The Regional Director with responsibility for the institution in which the suicide occurred, is asked for a response to the Jurys' recommendations and these in turn are considered at all levels for possible changes in policy or procedure.

In dealing with the great number of Coroner's recommendations including the foregoing cases where fault was found, it was decided to group them under the following headings: then note the number of times these recommendations have been made.

Safety
First Aid
Facility/Security
Communications
Psychiatric Services
Medical Services
Staff
Staff Routine
Other Agencies
Suicide Prevention

RECOMMENDATIONS:

Safety	6	Fire Safety as stated earlier in V.I.R.C.C. case.
	2	Phone system improvements (K.R.C.C.)
	2	Emergency First Aid and oxygen equipment placement and checking for adequacy.
	1	Master keys for emergency access to cells (V.I.R.C.C.)
	11	

First Aid	5	All Correctional Officers get mandatory First Aid Training. Improved training and maintain training with refresher courses.
	1	Special breathing apparatus training (V.I.R.C.C.)
	6	
Facility	4	New or improved remand facilities at L.M.R.C.C. as soon as possible.
Security	5	Better visibility for guards (including T.V. monitors, mirrors, lighting).
	2	Remove or restrict suicide implements (shoelaces, razors).
	1	Cover bars.
	12	
Communications	3	R.C.M.P. ←→ B.C. Corrections
	2	Riverview ←→ B.C. Corrections
	1	Psychiatry ←→ Correctional Officers
	1	Hospital ←→ Correctional Officers
	1	Inter-governmental committee vis-a-vis Order-in-Council transfers.
	1	Unrestricted access for inmates to outside groups (Lakeside)
	1	Citizens Advisory Committee separated from the influence of administration (Lakeside)
	10	

Psychiatric Services	5	Use alternative special observation facilities, hospital or psychiatric.
	4	Use community psychiatric facilities for known suicide attempters.
	4	One or more full-time psychiatrists at L.M.R.C.C.
	2	More counsellors, to save psychiatrist's time.
	1	A psychiatric interview for each new inmate.
	1	Group therapy for all inmates.
	1	Staff trained in recognizing mental problems.
	18	
Medical Services	3	24-hour medical staff.
	1	24-hour First Aid personnel.
	1	Better medical services.
	3	Better pharmacy distribution and control.
	1	Blood and urine tests to ensure inmates are taking medication (not hoarding).
	2	Resuscitation efforts should not before doctor arrives.
	11	
Staff	3	Increase staff (one guard each tier, one medication dispensing officer).
	1	Ratio of 2 staff to 20 inmates (L.W.C.C.)
	4	

Staff Routine	2	More frequent and irregular checks.
	1	Surveilance improved.
	1	Better checks on mental problems.
	1	Close contact with mental problems.
	1	Observation for new admissions.
	1	Ensure inmates breathing when rounds made.
	1	Full shifts worked.
	1	Proper rounds made.
	1	6 a.m. rounds with punch clock.
	10	
Other Agencies	2	Review Order in Council procedures.
	1	Court pay more attention to psychiatric reports.
	1	Coordination V.I.R.C.C. with Saanich Fire Department.
	4	
Suicide Prevention	1	Start suicide prevention program at Lakeside.
	1	Study of self-destructive acts.
	2	

ACTION TAKEN ON CORONER'S INQUEST RECOMMENDATIONS

Safety

Concerns regarding safety and particularly fire safety are now addressed both through local safety committees and the institutional inspection process. B.C. Corrections Inspectorswith representatives from the Workman's Compensation Board, Safety Programs, Fire Commissioner's Office and B.C. Buildings Corporation carefully examine living and working conditions in all Correctional institutions for safety and quality of facility management. Juvenile facilities are examined every year and adult facilities every two years.

Many Branch facilities are out of date and do not conform to the latest fire and safety codes; however, the facilities in these categories are planning to be phased out with alternative institutional plans on the drafting board, or in the advanced stages of planning. Replacement facilities are planned for L.M.R.C.C. (Oakalla), and L.W.C.C.(Lakeside). These are to be followed by replacement of K.R.C.C. (Kamloops) and extensive renovations to P.G.R.C.C. (Prince George). The new facility at V.I.R.C.C. (Wilkinson Road) is presently underway.

With regard to specific recommendations regarding fire safety at V.I.R.C.C. and in particular the matters of alkyd paint and smoke detectors, it was learned that tests were done with several fire retardant paints after sandblasting. The process of removing old paint and repainting (with limited advantage from a combustion standpoint) was assessed as impractical for existing structures. While the question of effectiveness of fire retardant paint in saving lives in any Possible future fires is not totally answered, the new facilities under construction are to be subject to new standards for fire safety including fire retardant paints and cell materials (see Service Delivery Standards, Physical Plant G1). The recommendation regarding smoke detectors was a much more practical and useful directive. As mentioned all new facilities have both combinations of heat and smoke detection equipment with annunciator panels. In addition, present facilities are being equipped with smoke and heat detectors as required in an ongoing program of updating and meeting fire and safety codes. All Community Correctional Centres now have detection equipment. Lakeside Correctional Centre, Willingdon Detention Centre and Lynda Williams have just completed smoke detection installations.

Improvements in telephone systems have been made in several instances; however, the recommendation for a master key for emergencies was considered impractical and impossible from a security standpoint.

First Aid

Since the first recommendations for First Aid Training were made the complement of First Aid Trained Correctional Officers has grown. All incoming officers are required to complete Block II Training at B.C.'s Justice Institute which includes First Aid and Cardiac Pulmonary Rescusitation work. It is necessary for every institution to have a stated number of First Aid Trained Officers with Industrial Certification who are represented on each shift at each institution.

Facility Security

As outlined under the previous heading "Safety", many of Coroner's recommendations regarding better or improved facilities particularly for remand prisoners, will be addressed in a definative way with the new facilities being planned and built.

In regard to the three recommendations to take away or restrict implements capable of being used for suicide, most Directors of institutions see these proposals as being impossible to implement or too impractical. When we consider that the majority of hangings are accomplished with bedding or clothing and the fact that only two suicides in ten years were traced to razor blades, we realize that restricting clothing or use of razors are impractical or somewhat naive recommendations. Special locking-type razors are available in our institutions for issue to those thought to be suicidal or prone to self-inflicted injury. As the American Study concludes, we would be better to concentrate suicide prevention efforts on staff personal contact and understanding rather than trying to restrict or outwit the potential suicider.

Where possible and practical, facility improvements have been made to augment surveillance, mirrors have been utilized in L.M.R.C.C. South Wing Observation and other areas where visual security is essential. We are reminded, however, of the importance of not relying on mechanical means of surveilance but rather counting on staff interaction with suicide potentials for more effective and meaningful prevention.

Communciation:

As noted, a number of inquests heard evidence that the victims suicidal tendencies were known to one or perhaps more persons but this was not always communicated to all staff who came in contact with the individual. Communication within the Branch, between institutions, within institutions and between agencies can be problematical at times and can, as we see, have serious consequences.

One positive step that was taken in November of 1981, was the colour tagging identification system of inmate files at L.M.R.C.C. Red tag (dangerous maximum security high profile), blue tag (suicidal) and yellow tag (protective custody). The decision to place these identification tags on files as a ready alert to staff would be made by the Classification Officer on the basis of information received from other staff. The Classification Officer would be responsible for tagging all files and the removal of tags after discussion with Local Director or Senior Officers concerned. These colour tags were to be placed on the front of the progress log, master file and warrant file to alert all staff responsible for the safety and custody of the individual inmate. (See page 152, Branch Suicide Procedures Section)

In the communications area we will always be striving for improvement with interpersonal contact and with physical communication equipment improvements. While we can never reach the ultimate, there have been several significant improvements in both technology and on the interpersonal front. Corrections-Police liaison is ever improving as it Sheriff-Corrections interaction. The new Vancouver Pretrial Services Centre in downtown Vancouver, is expected to improve both physical and interpersonal communication between Police, Sheriff and Corrections particularly to the advantage of the remand prisoner (that group with the highest suicide rate).

The new "Offenders Data Base" holding the Provincial Case Files with data terminal access represents our latest technical communications breakthrough. An admitting officer has ready access to a growing number of offender record files (now over 140,000) which can, through additional flagging on a "Comment Screen", advise that an admission is potentially suicidal, violent or in need of other specialized care or security. (Appendix K)

As mentioned, we will never have fool-proof communications as it will always gravitate down to the tier officer recording his observations on a particular inmate and passing those on to the next shift officer who in turn advises his replacement. This is the key in a constantly changing picture of continuity on inmate adjustment or lack of thereof.

The area of encouraging outside resources or other inmates to assist in suicide prevention is a wide-open field used informally by some experienced officers in our system and formally in some U.S. prisons, where inmate resources are employed to keep watch and assist with prisoners who are thought to be suicidal. (Appendix E)

Specific recommendations for communication improvement at L.W.C.C. (Lakeside) have been taken into consideration and acted upon as far as the Citizens Advisory Group is concerned. However, unrestricted access by any (and all) community groups was not felt to be reasonable, practical or necessarily related to self-inflicted injury in that institution.

Psychological Services

Again, while improvements have been made, we will perhaps never reach perfection in the area of providing Mental Health Services, or as one Jury recommended, "group therapy for every inmate."

When an inmate at LMRCC or in surrounding institutions is found to be unusually depressed, suicidal or injured in a suicide attempt, he is transferred to the Health Care Unit on LMRCC grounds, or Special Observation South Wing after his medical needs are addressed. Cases of serious injury would be transferred to nearest community hospitals.

The Branch has access to 24-hour medical services to be described next as well as regular sessional psychological and psychiatric consultation. Directors of psychological and medical services are closely involved with all Branch operations and L.M.R.C.C. (Oakalla) in particular.

In response to a Coroner's recommendation that the time consuming procedure of Order in Council to transfer psychiatric cases to a mental hospital be reviewed, an ammendment to the Mental Health Act was made. Emergency transfers to the Forensic Psychiatric Institute are no longer laborious but are affected in most cases quite quickly with two Doctors' signatures. This of course is assuming that there are bed spaces at F.P.I. which is quite often a problem causing delays in transfer.

Permanent or disputed transfers still require an Order in Council and transfers to other than the Forensic Institute remain problematic: i.e. community 'in patient' psychiatric facilities, deportation, or community cases on expiration of prison sentence.

While professional mental health services are highly desirable, having a well-trained regular staff who are aware of mental health problems in the inmates they deal with, provides a better front line of defence against self-destructive acts.

The recommendation to provide psychological interviews with each new admission (while totally impractical and inappropriate in dealing effectively with the problem) perhaps helped in promoting the idea of developing an admission screen. Using a questionnaire developed by psychologists, the psychological screen will be designed to tap feelings and identify possible cases of mental illness, depression and those admissions who might be potentially suicidal.

The development of the "Psyche Screen" is to be combined with a more comprehensive admission orientation information process which has been underway over the past two years aimed at both the identification of potential problems in the newcomer and reducing his or her level of anxiety by information and establishing an initial staff/inmate rapport. (Appendix F)

Medical Services

The delivery of medical health care has been the focus of a good deal of attention and action in recent years, particularly at L.M.R.C.C. Following the sensationalized Abdel Baky suicide of 1980 involving drug overdose with institutional prescription medication, the Coroner's Jury recommended a study of Branch Medical and Pharmacological Services. The College of Pharmacists of B.C. submitted their comprehensive report with findings and recommendations in June 1982. This report and its recommendations were under study by the Senior Medical Officer who chaired a special committee of Correctional, Medical and Pharmalogical

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(27) Reference is made to Ray Pearson's initiation of such a scheme. Memo of January 21, 1982. (Appendix F).

experts brought together for the express purpose of implementing improvements. The last meeting of that Committee and the recommendations to the March 1983 Branch Management Committee called for medical personnel to dispense/distribute medication. The Branch accepted this recommendation with a comittment for full implementation within 2 years. No doubt these recommendations and the new Medical Health Care Policy approved September 24, 1982, by B.M.C., will have an important and beneficial impact on inmate health care in our present institutions and those new facilities planned or under construction.

As to other Jury recommendations, LMRCC Health Care Centre provides 24-hour nursing service with physicians on 24-hour call in case of emergencies. Other smaller institutions (80 inmates and more)or any institution of entry will provide 24-hour nursing capability as well as having emergency doctors on call. Similarly each institution is required to have at least one staff member with Industrial First Aid Certification on duty at all times.

In the case of an inmate death or apparent suicide, the requirement of recussitation procedure to continue until the arrival of qualified medical personnel is mandatory.

Finally, the stricture by the Coroner's Jury in the Baky case to use blood and urinalysis tests on all inmates receiving medications to ensure they are in fact taking their medication was considered totally impractical. Alternative controls and procedures such as use of liquid medication, checking the mouth after oral medication is given and logging the issue of medication, is much more effective and proper monitoring by the nurse administering medications.

Staff

The call for increase in Correctional Staff has been echoed many times in the past, e.g. more manpower, one officer per tier, more counsellors, more medical staff, more psychiatric staff and better staff/inmate ratios.

While recognizing that line staff are the most important resource in any suicide prevention system it would appear, for the interim, there can be no increase in manpower due to the current restraint program that will be with us into the foreseeable future.

Given the fact that we are not likely to receive any increase in line staff, much less, specialized staff, it appears the only avenue for improvement of suicide prevention service will be through the better trained, more aware staff member who will hopefully be motivated to increase his or her effort in the area of self-inflicted injuries and in dealing with inmates who are suicidal.

Present Block II Training at the Justice Institute covers this topic efficiently and as effectively as possible under time and money constraints. See Appendix G for course outline and J.E. Laverock's training review for the Suicide Prevention Committee. Additions of new material, such as the Federal Government Training Package outline (Appendix H), including a video presentation may be considered worthy of expanding the time spent in this sector of training.

Staff Routine

Linked to the areas of staffing and staff training are the

Coroner's recommendations concerning staff routine which were,of course, aimed at prevention through better surveillance, control and contact between staff and inmates.

Of the 10 recommendations made in this area, most were simply aimed at better and more frequent checks of inmates. The desired objective of staff being more aware of mental problems among their inmate charges cannot be disputed. One must realize that routines can only be "legislated" or "regulated" by written Standards to ensure a certain basic level of minimum service is delivered. This may or may not be effective in suicide prevention. We have seen many cases where inmates can simply time their suicide attempt between staff rounds to ensure success.

Written policy defining procedures for 24-hour emergency services, are now an accepted part of Medical Standards. These plans outline the logistics, procedures and staff requirements for dealing with a wide variety of emergency situations with the view to providing service with efficiency and speed.

What seems to make for effective suicide prevention from a staff point of view is increased interest in this problem through suicide awareness programs. Once aware increased contact with potential victims by staff and possibly inmate volunteers could be expected to reduce the incidence of suicide. The fact that so many suicides have been successfully averted, discounting manipulative attempts, on more than a 25 to 1 ratio, attests to the fact that it can be done and is being done. Several recent cases at LMRCC have shown that keen interest and the extra alertness of staff makes the difference and saves lives.

Other Agencies

As noted, former roadblocks in the procedure for Order in Council transfers between Corrections and Provincial Mental Hospitals have been partially removed with amendments to the B.C. Mental Health Act. Bed space at F.P.I. and transfers to community psychiatric facilities, remain problematical.

Correspondence with Sheriff's Services and Police Departments on the issues of coordinated information sharing and communication relative to dangerous and suicidal inmates has been underway both in specific cases addressed by Coroner's Juries and in a general strategy to improve our systems.

In this regard, we may find conclusions such as those of the Correction Service Canada Study (Appendix I) valuable in assessing B.C. Corrections suicide data and improving our service delivery to inmates.

Suicide Prevention

The call for a study of self-destructive behaviour and for developing and implementing a suicide prevention strategy within B.C. Corrections Branch is herewith underway and continuing.

BRANCH SUICIDE PREVENTION PROCEDURES (Existing)

A key aspect of this study was to examine what policy and procedures were presently in place throughout the Branch to address the problem of self-inflicted injury and suicide attempts.

The compilation of this material was accomplished through two strategies:

A) A search was made of Branch Policy and Procedure Manuals for germaine instruction on identification, surveillance, prevention and the handling of critical incidents.

B) A questionnaire (Appendix J) was mailed to each institutional facility to inquire into the existence of written local policy on the above topics as well as inquire into staff training related to these and report any medical or other procedures which could be of value if shared throughout the Branch.

A. Branch Policy and Procedure

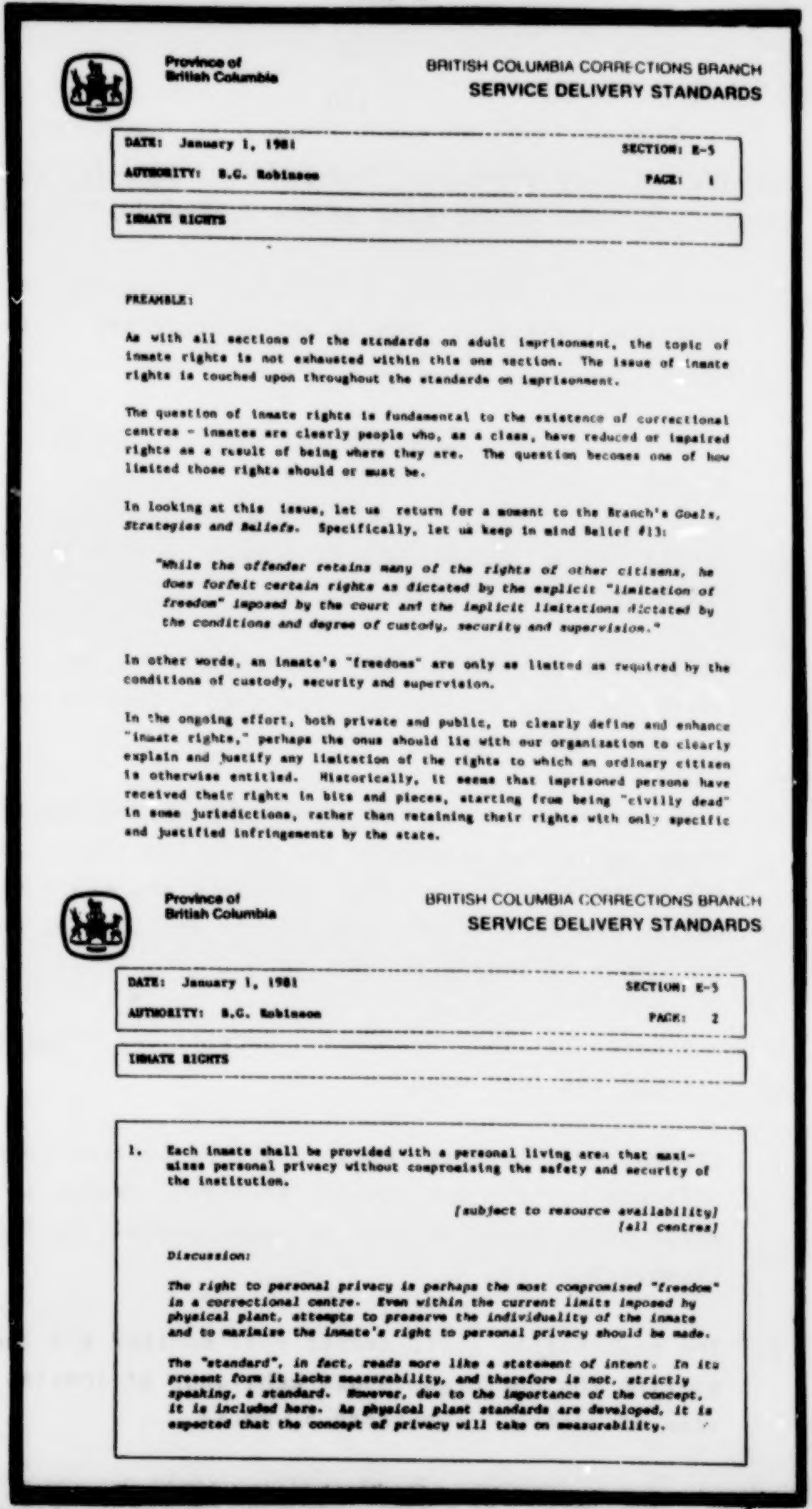
As outlined in Branch "Goals, Stategies and Beliefs", quoted under Service Delivery Standards, Section E5, Inmate Rights.

The offender retains many of the rights of other citizens even though he does forfeit certain rights as dictated by the explicit limitation of freedom imposed by the Court.....

As the first provision under Inmate Rights states: (Section E-5,pp.2) (1) Each inmate shall have a personal living area that maximizes personal privacy without compromising safety and security of the institution.

Implicit in the right to privacy is the right to safety and security of person.

Having thus outlined the Branch intent to provide safe custody, we examine the pragmatic procedures for fulfilling this "guarantee".



Province of
British Columbia

BRITISH COLUMBIA CORRECTIONS BRANCH
SERVICE DELIVERY STANDARDS

DATE: January 1, 1981	**SECTION:** E-5
AUTHORITY: B.G. Robinson	**PAGE:** 1

INMATE RIGHTS

PREAMBLE:

As with all sections of the standards on adult imprisonment, the topic of inmate rights is not exhausted within this one section. The issue of inmate rights is touched upon throughout the standards on imprisonment.

The question of inmate rights is fundamental to the existence of correctional centres - inmates are clearly people who, as a class, have reduced or impaired rights as a result of being where they are. The question becomes one of how limited those rights should or must be.

In looking at this issue, let us return for a moment to the Branch's *Goals, Strategies and Beliefs*. Specifically, let us keep in mind Belief #13:

> *"While the offender retains many of the rights of other citizens, he does forfeit certain rights as dictated by the explicit "limitation of freedom" imposed by the court and the implicit limitations dictated by the conditions and degree of custody, security and supervision."*

In other words, an inmate's "freedoms" are only as limited as required by the conditions of custody, security and supervision.

In the ongoing effort, both private and public, to clearly define and enhance "inmate rights," perhaps the onus should lie with our organization to clearly explain and justify any limitation of the rights to which an ordinary citizen is otherwise entitled. Historically, it seems that imprisoned persons have received their rights in bits and pieces, starting from being "civilly dead" in some jurisdictions, rather than retaining their rights with only specific and justified infringements by the state.

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BRITISH COLUMBIA CORRECTIONS BRANCH
SERVICE DELIVERY STANDARDS

DATE: January 1, 1981	**SECTION:** E-5
AUTHORITY: B.G. Robinson	**PAGE:** 2

INMATE RIGHTS

1. Each inmate shall be provided with a personal living area that maximizes personal privacy without compromising the safety and security of the institution.

[subject to resource availability]
[all centres]

Discussion:

The right to personal privacy is perhaps the most compromised "freedom" in a correctional centre. Even within the current limits imposed by physical plant, attempts to preserve the individuality of the inmate and to maximize the inmate's right to personal privacy should be made.

The "standard", in fact, reads more like a statement of intent. In its present form it lacks measurability, and therefore is not, strictly speaking, a standard. However, due to the importance of the concept, it is included here. As physical plant standards are developed, it is expected that the concept of privacy will take on measurability.

Service Delivery Standards, Section E-2, Security and Control, provide instruction on the following:

1. An additional "ongoing, informal, unscheduled count" to keep staff aware of inmates and activities. (Standard 8, pp. 6).

2. Half hour visual inspection of inmates confined to cells in secure settings. (Standard 9, pp. 6).

3. Hourly visual inspections of inmates housed in open settings. (Standard 10, pp. 7)

4. Policy for control of contraband (weapons, drugs etc.) posted clearly and obvious for staff, inmates and visitors. (Standard 11, pp. 8)

5. Each Correctional Centre to develop written contingency plans detailing responses and assigning responsibilities for responding to critical incidents and staff should review and know their roles in preparation for each incident. (Standard 16, pp. 10)

Under Service Delivery Standards, Section E-3, "Supervision of Inmates" the following:

1. Correctional Officers posts shall be located to permit officers to hear and respond to inmate needs, in other words to be aware of what is happening within the Unit. (Standard 4, pp. 4)

2. The responsible staff member will monitor and record in writing the performance and behaviour of inmates in his area of control. (Standard 5, pp.4)

3. The assignment of a staff "Case Manager" to each sentenced inmate within a week of arrival for those serving more than 30 days. (Standard 6, pp.6)

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BRITISH COLUMBIA CORRECTIONS BRANCH

SERVICE DELIVERY STANDARDS

DATE: January 1, 1981 **SECTION: E-2**

AUTHORITY: B.G. Robinson **PAGE: 6**

SECURITY AND CONTROL

8. An informal count shall be taken of inmates at various and unscheduled times and under situations not included in the formal count.

[effective immediately]
[secure, open and community correctional centre settings]

Discussion:

An ongoing informal counting procedure helps to keep staff aware of the placement of inmates within the facility.

9. A visual inspection of each individual's cell or room and the area immediately surrounding each housing unit shall be conducted by correctional centre staff at intervals not to exceed 1/2 hour when inmates are confined in their individual housing units.

[effective immediately]
[secure settings]

Discussion:

It is imperative that staff be aware of what is happening in their particular area of responsibility. The major emphasis for such knowledge should be the well-being of the inmates under their care and control. These inspections should be at irregular intervals so as not to form a set and predictable pattern.

10. A visual inspection of each individual's cell or room and the area immediately surrounding each housing unit shall be conducted by correctional centre staff at intervals not to exceed 1 hour when inmates are confined in their individual housing units.

[effective immediately]
[open settings]

Discussion:

It is imperative that staff be aware of what is happening in their particular area of responsibility. The major emphasis for such knowledge should be the well-being of the inmates under their care and control. These inspections should be at irregular intervals so as not to form a set and predictable pattern. The reduced number of inspections reflects the security applied to persons in open settings.

11. Each correctional centre shall post its policy for the control of contraband in a manner that is clear and obvious to staff, inmates and visitors.

[effective immediately]

Discussion:

All persons entering a correctional centre for any purpose need to know the potential impact of the bringing and keeping of contraband items. Therefore, the centre's policy regarding contraband should be posted in a manner that is obvious and attracts the attention of any affected person.

Due to the differing circumstances which apply in secure versus open and community settings, with the exception of drugs and weapons a uniform definition of contraband to apply universally within the Branch is not possible. It is therefore incumbent upon the director to list and post those items which are contraband in his or her particular circumstances. Individual policy on the definition of contraband shall, however, be consistent with whatever provincial policy is written in this area.

Province of British Columbia

BRITISH COLUMBIA CORRECTIONS BRANCH

SERVICE DELIVERY STANDARDS

DATE: January 1, 1981 **SECTION: E-2**

AUTHORITY: B.C. Robinson **PAGE: 10**

SECURITY AND CONTROL

16. All correctional centres shall develop and maintain written contingency plans detailing responses and assigning responsibilities for responding to critical incidents.

[effective immediately]
[all centres]

Discussion:

This standard addresses the need for correctional administrators to have clearly detailed procedures and assignments for staff members in the event of a variety of emergency situations. All staff members must be aware of their roles and responsibilities prior to any such incident.

Province of British Columbia

BRITISH COLUMBIA CORRECTIONS BRANCH

SERVICE DELIVERY STANDARDS

DATE: January 1, 1981 **SECTION: E-3**

AUTHORITY: B.C. Robinson **PAGE: 4**

SUPERVISION OF INMATES

4. Correctional officer posts shall be located so as to permit officers to hear and respond to indications of inmate needs.

[effective immediately]
[secure settings]

Discussion:

It is necessary that staff be located as close as possible to inmate living areas in order to be aware of what is happening within the unit, to maintain security and control, and to respond to inmate needs.

5. A staff member responsible for supervising a program of inmate activity shall monitor and record in writing the performance and behaviour of inmates assigned to that program.

[effective immediately]
[all centres]

Discussion:

Records should be kept on inmate performance in order to facilitate program planning and community re-entry.

6. All sentenced inmates shall be assigned a case manager within 1 week of arrival at the centre to which he/she is classified.

[effective immediately]
[all centres]

Discussion:

The issue of minimum sentence length before eligibility for assignment to a case manager is not addressed in this set of standards. However, it is recognized that elaborate case planning for persons serving intermittent sentences and/or sentences of less than 30 days is unnecessary.

Under Service Delivery Standards, Section E-4,
Special Management Inmates

1. Branch to identify those inmates with special needs and house them in a manner to ensure that needs for safe custody and rights and privileges are met. (Standard 1, pp. 2)

2. Inmates segregated for disciplinary purposes are to be similarly housed with provision for the removal of material the Director deems potentially hazardous to the inmate or others. (Standard 3, pp. 3)

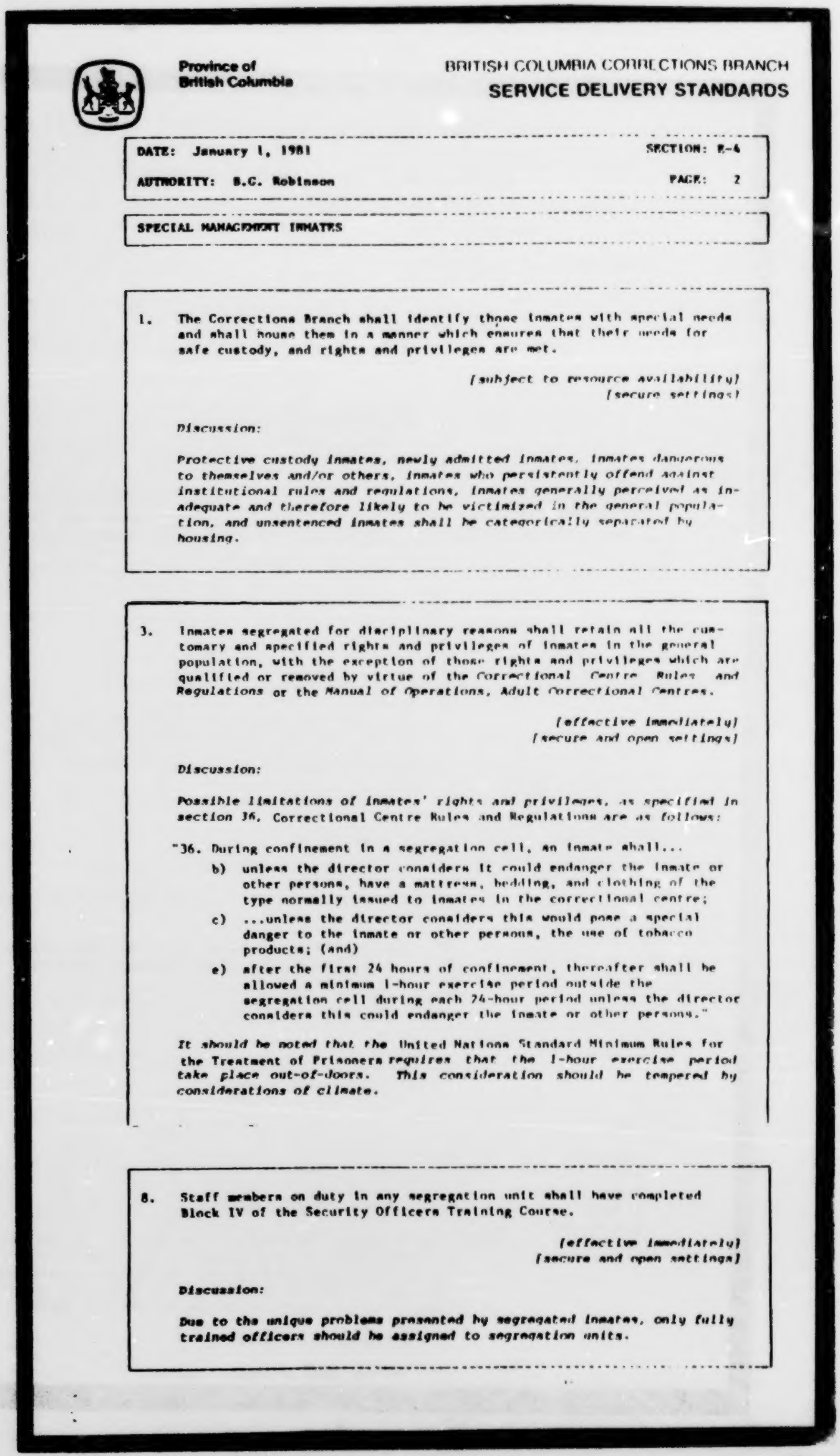
3. Staff members on duty in any Segregation Unit shall have completed Block IV of the Security Officers Training Course which includes special suicide prevention instruction. (Standard 8, pp. 6)

Under Manual of Operations
Adult Institutional Services
Authority and Administration - Correctional Centre,
Section A-2

Critical Incidents Notification Requirements stipulates:

1. Immediate telephone notification to the Regional Director, Commissioner's Office and the Director of Inspection & Standards.

2. Verbal notifiction to be followed by written reports from all on duty staff prior to going off shift after termination of an incident. (Standards 5.01 & 5.02, 5.03, pp. 5 - 6)



Province of
British Columbia

BRITISH COLUMBIA CORRECTIONS BRANCH
SERVICE DELIVERY STANDARDS

DATE: January 1, 1981 **SECTION: E-4**

AUTHORITY: B.G. Robinson **PAGE: 2**

SPECIAL MANAGEMENT INMATES

1. The Corrections Branch shall identify those inmates with special needs and shall house them in a manner which ensures that their needs for safe custody, and rights and privileges are met.

[subject to resource availability]
[secure settings]

Discussion:

Protective custody inmates, newly admitted inmates, inmates dangerous to themselves and/or others, inmates who persistently offend against institutional rules and regulations, inmates generally perceived as inadequate and therefore likely to be victimized in the general population, and unsentenced inmates shall be categorically separated by housing.

3. Inmates segregated for disciplinary reasons shall retain all the customary and specified rights and privileges of inmates in the general population, with the exception of those rights and privileges which are qualified or removed by virtue of the *Correctional Centre Rules and Regulations* or the *Manual of Operations, Adult Correctional Centres*.

[effective immediately]
[secure and open settings]

Discussion:

Possible limitations of inmates' rights and privileges, as specified in section 36, Correctional Centre Rules and Regulations *are as follows:*

"36. During confinement in a segregation cell, an inmate shall...
- b) unless the director considers it could endanger the inmate or other persons, have a mattress, bedding, and clothing of the type normally issued to inmates in the correctional centre;
- c) ...unless the director considers this would pose a special danger to the inmate or other persons, the use of tobacco products; (and)
- e) after the first 24 hours of confinement, thereafter shall be allowed a minimum 1-hour exercise period outside the segregation cell during each 24-hour period unless the director considers this could endanger the inmate or other persons."

It should be noted that the United Nations Standard Minimum Rules for the Treatment of Prisoners *requires that the 1-hour exercise period take place out-of-doors. This consideration should be tempered by considerations of climate.*

8. Staff members on duty in any segregation unit shall have completed Block IV of the Security Officers Training Course.

[effective immediately]
[secure and open settings]

Discussion:

Due to the unique problems presented by segregated inmates, only fully trained officers should be assigned to segregation units.

B. C. CORRECTIONS BRANCH - MANUAL OF OPERATIONS
ADULT INSTITUTIONAL SERVICES

Date: August 15, 1983 Section: A2
Authority: B. G. Robinson Page: 5

AUTHORITY & ADMINISTRATION - CORRECTIONAL CENTRES

CRITICAL INCIDENTS NOTIFICATION REQUIREMENTS

5.01 The following notification instruction can be found in the various sections of the manual dealing with individual subject matter. They are repeated here for quick reference.

Immediate telephone notification

5.02 Incidents of the following nature require that immediate notification by telephone be given to the regional director or his designate, the Commissioner of Corrections, and the Director, Inspection & Standards. Verbal communication is to be followed by written reports completed by all involved on-duty staff prior to going off shift at termination of incident, whenever practical.

1. Riot/Disturbance

   For the purpose of this directive a riot/disturbance will be defined as a situation which cannot be dealt with by staff on shift at the work location at the time of the occurrence. Where the situation was dealt with by staff immediate notification is not required, but a written report nevertheless should be submitted.

2. Hostage Taking

3. Suicide/Death of an Inmate or Staff Member

   Staff fatalities are also to be reported immediately to:

   (a) the Ministry Safety and Training Officer, Personnel Services Headquarters, Victoria;

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Notification by next working day

5.03 The following incidents will be reported to the regional director, or his designate; the Commissioner of Corrections; and the Director, Inspection & Standards, no later than the commencement of the next working day. Written reports to follow, as per 5.02 above.

1. Discharge of Firearms;

2. Serious Staff or Inmate Injuries.

Authority and Administration, Section A-3

Referral of Inmates to Human Resources for Assistance upon Discharge.

1. Staff are encouraged to telephone the District Human Resources Office well in advance of an inmate's release to arrange for an appointment on the day of discharge. Form #7706 will be issued as interm identification if needed. (Standards 4.01 pp 4)

   Special problems or inmate needs should be conveyed particularly if the inmate has shown suicidal intentions.

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ADMINISTRATION

REFERALL OF INMATES TO M.H.R. FOR ASSISTANCE UPON DISCHARGE

Release
Referrals
Corrections
M.H.R.
Agreement

4.01 As a result of some confusion around the procedures in referring ex-inmates of the B. C. Corrections Branch to Human Resources' offices for assistance when this is needed, a procedure has been established for proper referrals of such individuals. Corrections' staff are requested to telephone ahead well in advance to the District Office of the Ministry of Human Resources to arrange for an appointment on the day of discharge. The application will be taken at the time of the appointment in accord with Ministry policies and, if the applicant is eligible, emergency assistance will be issued, if required, at that time. Generally, these individuals fall into the category of transient men and women who are actively seeking employment and desirous of settling in the community. Ministry of Human Resources, Volume I, Income Assistance Manual (1.49 - 1.50, paragraph 3(b) details the manner in which all such applications can be assisted.

Given that correctional centres can verify the identity of the ex-inmate, Form #7706 could be used when necessary as interim identification until proper identification has been obtained and verified.

This procedure has been agreed to by the Commissioner of Corrections and the Deputy Ministry of Human Resources.

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FORM # 7706

REFERRAL TO A DISTRICT OFFICE OF THE MINISTRY OF HUMAN RESOURCES

DATE: ______________________

Name of Referring Institution: ______________________

Name of Applicant: ______________________

Also Known As: ______________________

Date of Birth: ______________________

Social Insurance Number: ______________________

This is to verify that the above named has been discharged from this institution on (date): ______________________
and is being provided with this letter as initial assitance may be required to become re-established.

Signed: ______________________

Phone No. for confirmation, if necessary: ______________________

Manual of Operations
Adult Institutional Services.

Accident Prevention, Section C-1

Industrial First Aid Certificates:

1. Staff members holding First Aid Certificates and performing first aid duties, will be given extra renumeration. (Standard 4.01 p. 4)

2. Number of First Aid Certificates per facility established.

3. Inspection & Standards role in certification, authorization and notification of expiry of First Aid Certification. (Standards 4.01-4.06, pp. 4-5)

Health - Inmates, Section C-3

Inmate Injury Report:

1. Report of Inmate Youth Injury, Form #7615, shall be completed by the officer supervising an injured inmate. (Section M1 p. 15)

2. Supervising officer to provide a brief narrative detailing how the injury occurred. (Standard 1.01 - 1.06 p. 1)

3. Senior Officer and Medical Officer provide their reports to the Director within 24 hours. (Standard 1.03 p. 1)

4. The Director shall add his comments recommending or not recommending a Board of Inquiry. (Standard 1.04 p. 1)

5. The Injury Report is then forwarded to unit/district directors and Ministry Safety Officer. The latter officer then forwards same to the Director of Inspection & Standards. (Standards 1.05 p. 1)

6. In cases of serious injury, where there is the likelihood of permanent disability, when procedures were not followed or were inadequate, or where there is negligence, a Board of Inquiry shall be held. The Board shall be held within one week of the injury. (Standard 2.01 - 2.08 p. 2)

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ACCIDENT PREVENTION

INDUSTRIAL FIRST AID CERTIFICATES

Remuneration 4.01 Remuneration will be paid pursuant to current Collective Agreements to those staff members holding valid Industrial First Aid Certificates and performing first aid duties.

Establishment 4.02 The number of staff members receiving remuneration for Industrial First Aid Certificates must be within the establishment for each facility.

Authorization for remuneration 4.03 (a) Authorization for remuneration to staff members holding Industrial First Aid Certificates shall be given by the Director, Inspection & Standards.

(b) A request for authorization shall be sent to the Director, Inspection & Standards, and a copy of a valid Industrial First Aid Certificate for the staff member for whom authorization is requested must accompany the request.

Deletion of certificate holder 4.04 Should there be a deletion of a staff member eligible for remuneration as holder of a valid Industrial First Aid Certificate, notification of such deletion shall be given to the Director, Inspection & Standards.

Notification of expiration of certificate 4.05 (a) Notification of the expiration of Industrial First Aid Certificates shall be given by the Director, Inspection & Standards, and it shall be the duty of the staff member to renew his certificate. A copy of the new certificate shall be sent to the Director, Inspection & Standards.

(b) Should a staff member not renew his certificate prior to the expiration date, he will no longer be entitled to remuneration as holder of same.

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INDUSTRIAL FIRST AID CERTIFICATES (cont'd)

Change of certificate status 4.06 Should the status of a staff member's certificate be changed, the Director, Inspection & Standards, shall be notified and a copy of the new certificate shall be forwarded with such notification.

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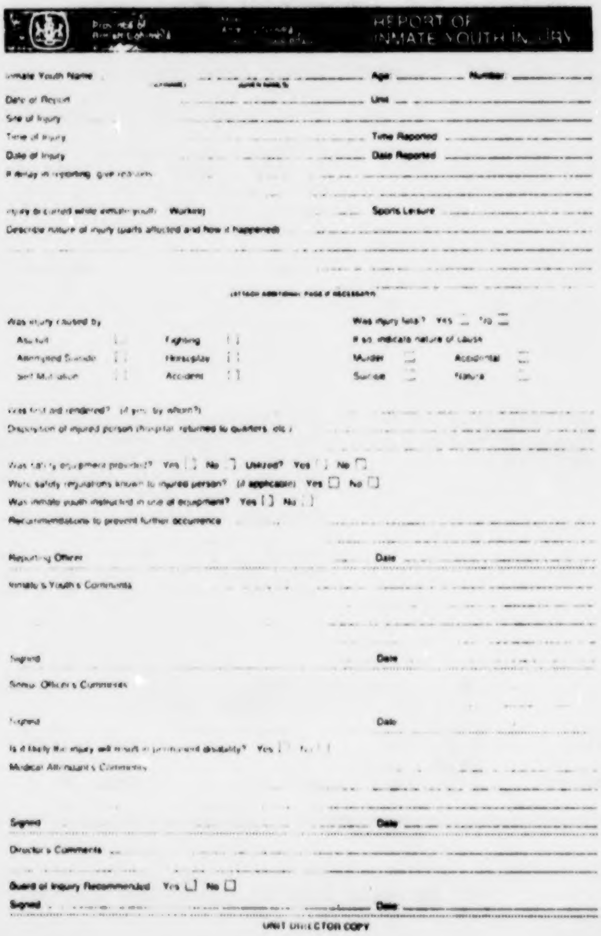
#7615 **MINISTRY OF ATTORNEY GENERAL - REPORT OF INMATE INJURY**



Province of British Columbia

REPORT OF INMATE YOUTH INJURY

Inmate Youth Name ______ Age ______ Number ______

Date of Report ______ Unit ______

Site of Injury ______

Time of Injury ______ Time Reported ______

Date of Injury ______ Date Reported ______

If delay in reporting, give reasons ______

Injury occurred while inmate youth: Working ______ Sports Leisure ______

Describe nature of injury (parts affected and how it happened) ______

(ATTACH ADDITIONAL PAGE IF NECESSARY)

Was injury caused by

Assault ☐ Fighting ☐
Attempted Suicide ☐ Horseplay ☐
Self Mutilation ☐ Accident ☐

Was injury fatal? Yes ☐ No ☐

If so, indicate nature of cause

Murder ☐ Accidental ☐
Suicide ☐ Natural ☐

Was first aid rendered? (if yes, by whom?) ______

Disposition of injured person (hospital, returned to quarters, etc.) ______

Was safety equipment provided? Yes ☐ No ☐ Utilized? Yes ☐ No ☐

Were safety regulations known to injured person? (if applicable) Yes ☐ No ☐

Was inmate youth instructed in use of equipment? Yes ☐ No ☐

Recommendations to prevent further occurrence ______

Reporting Officer ______ Date ______

Inmate's Youth's Comments ______

Signed ______ Date ______

Senior Officer's Comments ______

Signed ______ Date ______

Is it likely the injury will result in permanent disability? Yes ☐ No ☐

Medical Attendant's Comments ______

Signed ______ Date ______

Director's Comments ______

Board of Inquiry Recommended Yes ☐ No ☐

Signed ______ Date ______

UNIT DIRECTOR COPY

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HEALTH - INMATES

INMATE INJURY REPORTS

Injury Report

1.01 In the event of an injury to an inmate, Form #7615 - Report of Inmate/Youth Injury shall be completed by the officer supervising the inmate, including a signed statement by the inmate, and submitted to the senior officer in charge of the unit on any given shift.

Details of injury

1.02 A brief narrative report covering details of the injury and how it occurred shall be entered in the report by the supervising officer. The 'unit' referred to in Form #7615 should indicate the name of the correctional centre where the injury took place. The "nature of injury" should describe the injuries sustained by the inmate as accurately as possible.

Comments of senior and medical officer

1.03 The senior officer in charge of the unit and the medical officer in attendance shall add their comments to the medical report, indicating extent of injury and treatment given and/or proposed and forward the report to the local director of the centre within 24 hours of the injury.

Local Director's comments

1.04 The local director shall add his comments and indicate whether a Board of Inquiry is recommended (see Section C3, p.2, 2.02).

Distribution of report

1.05 Upon completion, a copy of the injury report shall be forwarded to:

1. unit director;
2. district director;

3. Ministry Safety and Training Officer, Personnel Services Headquarters, Victoria;
4. medical office file.

Notification

1.06 The regional director, or his designate, the Commissioner of Corrections and the Director, Inspection and Standards shall be notified by telephone immediately in the case of inmate deaths and serious assaults, and no later than the commencement of the next working day in the case of serious injuries to inmate. This verbal communication is to be followed by the usual Report of Inmate/Youth Injury completed by all involved on-duty staff and distributed in the usual manner with additional copies being sent to those notified verbally.

Serious injury is defined as one requiring hospitalization rather than first aid treatment.

HEALTH - INMATES

BOARD OF INQUIRY - INMATE INJURIES

Members

2.01 The members of a Board of Inquiry shall consist of the Director or Deputy Director as Chairperson and two or three senior staff members.

Permanent disability

2.02 Following an injury to an inmate, a Board of Inquiry shall be held within one week of the injury, where:

(a) the injury is likely to result in a permanent disability or handicap to the inmate;

Staff negligence

(b) where there is a possibility that procedures have not been followed, or that they are inadequate, or there is negligence.

Medical prognosis

2.03 The Board of Inquiry will be held even though the final medical prognosis is not completed and the final report may have to wait until the medical report is available.

Inmate statement

2.04 A signed and dated statement from the inmate, giving his version of the accident and treatment administered, shall be obtained as soon after the accident as the condition of the inmate will allow.

Witnesses

2.05 A signed and dated statement shall be obtained from all staff and inmate witnesses as soon after the accident as possible.

Proceedings of Board of Inquiry

2.06 One copy of the proceedings of the Board of Inquiry is to be forwarded to the Regional Director of Corrections and one copy to the Director, Inspection and Standards.

2.07 A complete set of the proceedings will consist of the following:

Injury report

(a) Injury report carefully and accurately filled out within 24 hours of the injury. All comments and narratives dated and signed.

Transcript

(b) Complete transcript of the hearing.

Statements

(c) Statements from the injured inmate, staff witnesses and inmate witnesses.

Statement of Medical Officer

(d) A dated and signed statement from the Medical Officer attending the injury, giving his prognosis, plus copies of laboratory reports, X-ray reports, etc., if these services are used.

(e) The regular mimeographed covering Form #7610 for Boards of Inquiry, listing members, evidence of witnesses, treatment given and conclusions of the Board of Inquiry.

Chairperson

2.08 The Chairperson of the Board of Inquiry is responsible for presenting an accurate, consistent and fully documented account of how the injury occurred and treatment administered or planned for the future, and what precautions can be taken to prevent similar injuries from occurring again.

Psychiatric Reports (Section C-3 (Continued)

1. Psychiatric reports may be made available to staff other than Crown Counsel, Parole Board Members and Probation Officers, when in the opinion of the Senior Medical Officer the information is such that it may protect the public or the inmate and the appropriate authorities should be advised of its content. (Standard 5.01, pp.5)

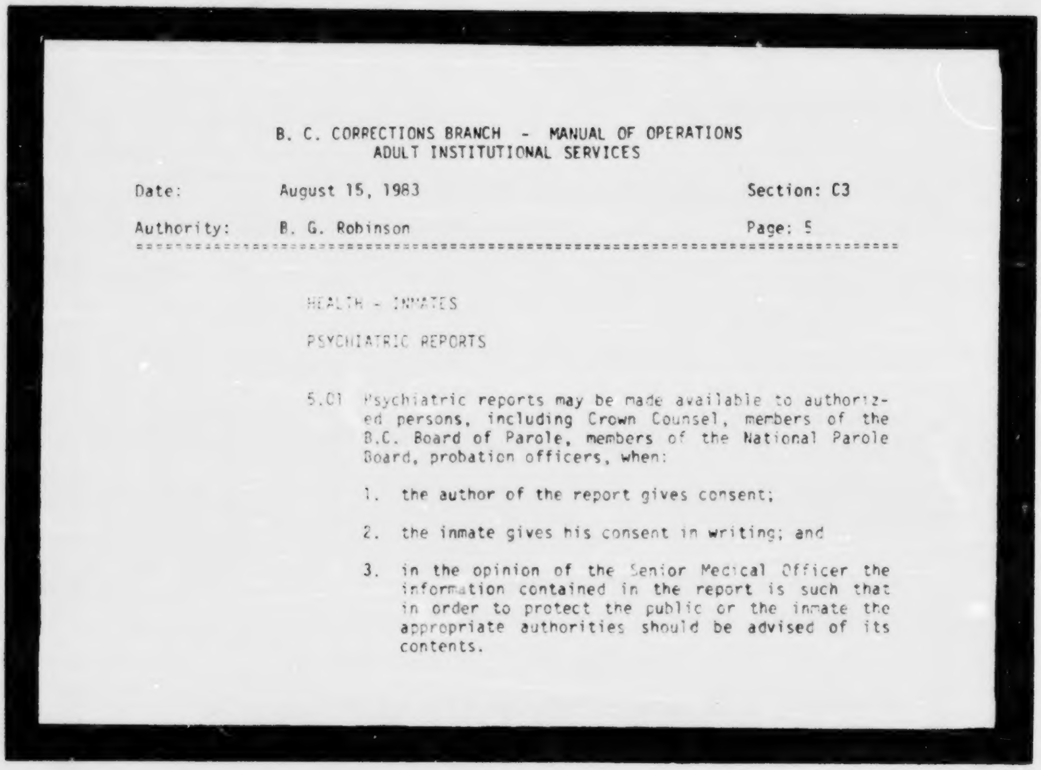
Inmate Mental Health

1. B.C.C.B. is required to notify R.C.M.P. of the imminent release of a mentally disturbed inmate who has attempted suicide, is believed to be suicidal or who has made threats of violence toward police officers or other persons.(Standard 8.01, p. 8)

2. Transfer of an inmate to a mental health facility requires the District Director's approval and either;

   (a) certificates from two doctors under Section 20 of the Mental Health Act and an application for admission under Section 25(1a) of the Mental Health Act.(used for immediate transfers); or

   (b) a copy of the Warrant of Committal is sent together with two Doctor's Certificates to the Administrative Officer of the Attorney General's office where a required Order in Council is prepared. (used for more permanent transfers) (Standard 8.02, p. 8-9)



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HEALTH - INMATES

PSYCHIATRIC REPORTS

5.01 Psychiatric reports may be made available to authorized persons, including Crown Counsel, members of the B.C. Board of Parole, members of the National Parole Board, probation officers, when:

1. the author of the report gives consent;
2. the inmate gives his consent in writing; and
3. in the opinion of the Senior Medical Officer the information contained in the report is such that in order to protect the public or the inmate the appropriate authorities should be advised of its contents.

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HEALTH - INMATES

INMATE MENTAL HEALTH

Notification to R.C.M.P.

8.01 When an inmate who is nearing discharge is believed by the institution to be mentally disturbed, has attempted suicide during incarceration, or is believed to have suicidal intentions, or has made threats of violence toward police officers or any other person, such information shall be communicated on form #7807 Inmate Release from Correctional Centre, to:

Crime Index Section
R.C.M.P.
1200 West 73rd Avenue
Vancouver, B.C.
V6P 6G6

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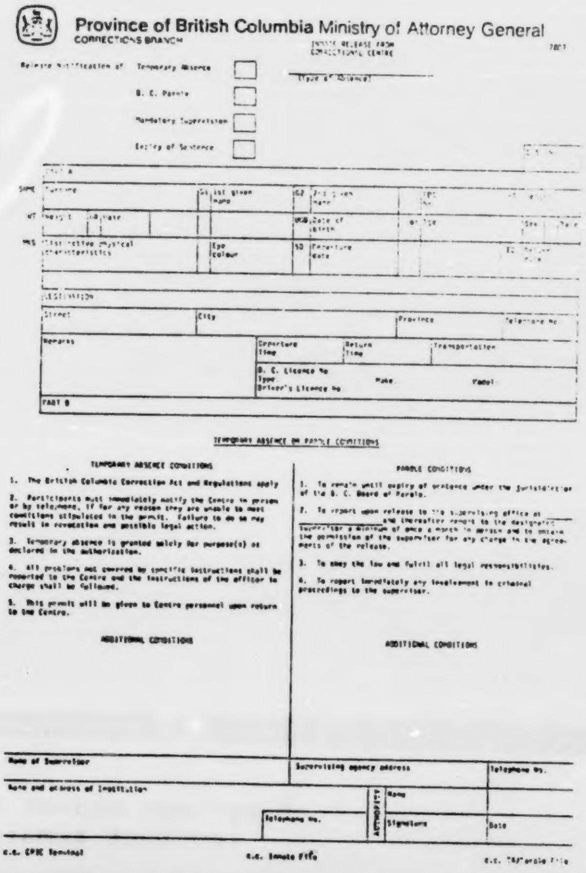
#7807



Province of British Columbia Ministry of Attorney General
CORRECTIONS BRANCH

INMATE RELEASE FROM CORRECTIONAL CENTRE

Release Notification of
Temporary Absence ☐
B. C. Parole ☐
Mandatory Supervision ☐
Expiry of Sentence ☐

(Type of Absence)

PART A

Surname
1st given name
2nd given name
Height
Weight
Date of birth
Sex
Distinctive physical characteristics
Eye colour
Departure date
Release date

DESTINATION

Street	City	Province	Telephone No

Remarks	Departure Time	Return Time	Transportation
	B. C. Licence No Type Driver's Licence No	Make	Model

PART B

TEMPORARY ABSENCE OR PAROLE CONDITIONS

TEMPORARY ABSENCE CONDITIONS

1. The British Columbia Correction Act and Regulations apply

2. Participants must immediately notify the Centre in person or by telephone, if for any reason they are unable to meet conditions stipulated in the permit. Failure to do so may result in revocation and possible legal action.

3. Temporary absence is granted solely for purpose(s) as declared in the authorization.

4. All problems not covered by specific instructions shall be reported to the Centre and the instructions of the officer in charge shall be followed.

5. This permit will be given to Centre personnel upon return to the Centre.

ADDITIONAL CONDITIONS

PAROLE CONDITIONS

1. To remain until expiry of sentence under the jurisdiction of the B. C. Board of Parole.

2. To report upon release to the supervising office at ______ and thereafter report to the designated supervisor a minimum of once a month in person and to obtain the permission of the supervisor for any change in the agreements of the release.

3. To obey the law and fulfil all legal responsibilities.

4. To report immediately any involvement in criminal proceedings to the supervisor.

ADDITIONAL CONDITIONS

Name of Supervisor	Supervising agency address		Telephone No.
Name and address of institution	AUTHORITY	Name	
Telephone No.		Signature	Date

c.c. CPIC Terminal
c.c. Inmate File
c.c. TA/Parole File

B. C. CORRECTIONS BRANCH - MANUAL OF OPERATIONS
*** ADULT INSTITUTIONAL SERVICES**

Date: January 30, 1982* Section: C3

Authority: B. G. Robinson Page: 8

Transfers - mental facility

* 8.02 When it becomes necessary to transfer an inmate to a provincial mental health facility a Local Director, upon the written approval of the District Director, may effect the transfer in either of the following procedures.

(a) By preparing the following documents and sending them to the Director of a mental health facility.

(i) certificates from two doctors in the form required by section 20 of the Mental Health Act.

(ii) an application for admission in the form prescribed in section 25(1a) of the Mental Health Act.

Upon receipt of the above documentation the director of a mental health facility may admit the inmate to that facility for treatment. Length of stay shall be in accordance with section 25(3) of the Mental Health Act.

(b) By obtaining the same documentation as stated in subsection a (i & ii) and sending them along with a copy of the inmates Warrant of Committal to

Administrative Officer
Criminal Law Section
Ministry of Attorney General
609 Broughton Street
Victoria, B. C.
V8V 1X4

The administrative officer will prepare and process the required order in council. The inmate is not to be transferred until the order in council has been issued.

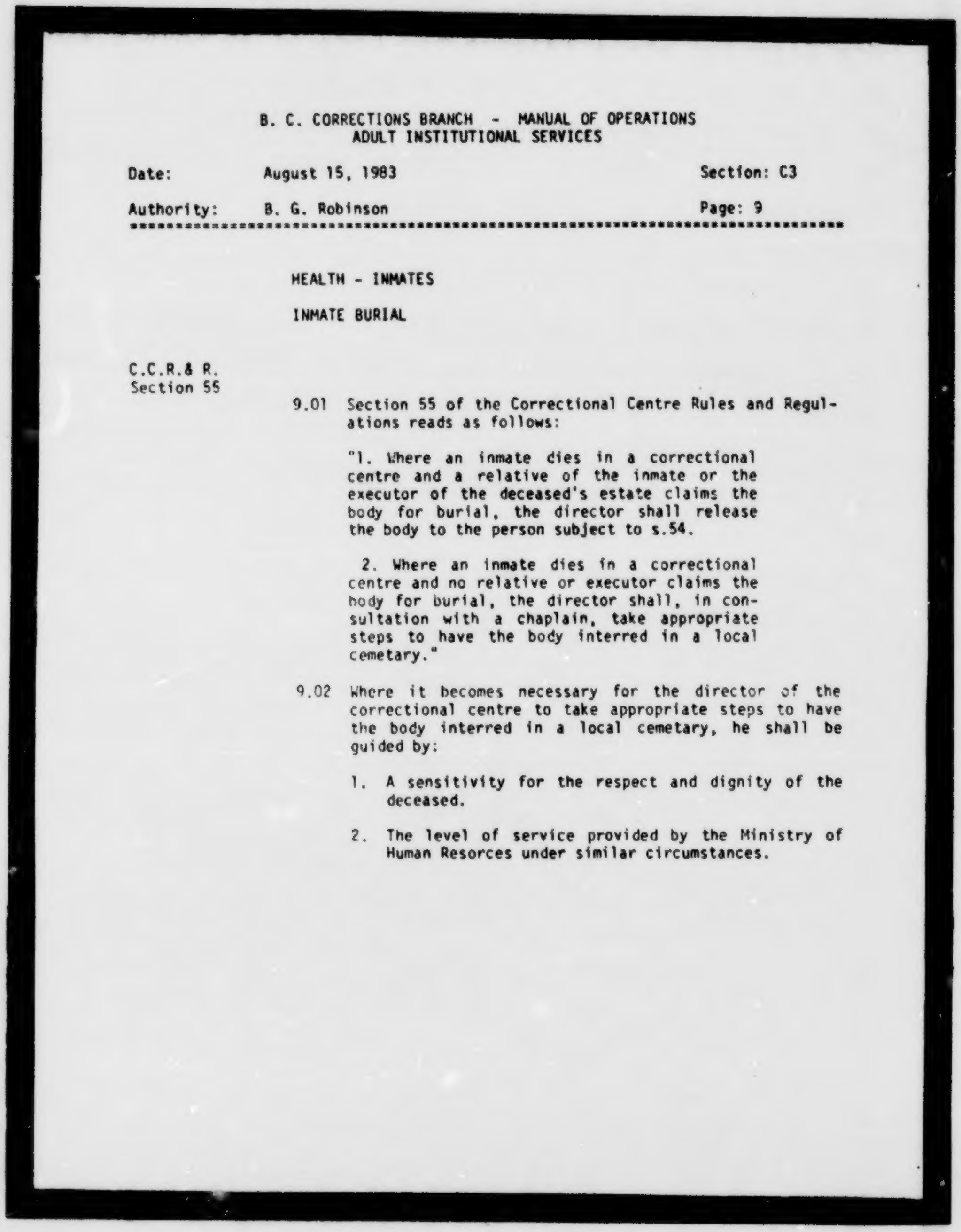
* Revised August 15, 1983
(content remains unchanged)

Inmate Burial Section C-3 (Continued)

1. The Director shall release the body of an inmate who has died in custody to a relative of the inmate or the executor of the deceased's estate claiming the body for burial under Correctional Centre Rules & Regulations, (Section 55. 9.01, 9.02, p. 9)

2. The Director shall, in consultation with the Chaplain, take appropriate steps to have the body interred in a local cemetery where no relative or executor claims the body.

3. In the later instance, the Director will be guided by respect for the dignity of the deceased and the level of service provided by the Ministry of Human Resources under similar circusmtances.



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HEALTH - INMATES

INMATE BURIAL

C.C.R.& R.
Section 55

9.01 Section 55 of the Correctional Centre Rules and Regulations reads as follows:

> "1. Where an inmate dies in a correctional centre and a relative of the inmate or the executor of the deceased's estate claims the body for burial, the director shall release the body to the person subject to s.54.
>
> 2. Where an inmate dies in a correctional centre and no relative or executor claims the body for burial, the director shall, in consultation with a chaplain, take appropriate steps to have the body interred in a local cemetary."

9.02 Where it becomes necessary for the director of the correctional centre to take appropriate steps to have the body interred in a local cemetary, he shall be guided by:

1. A sensitivity for the respect and dignity of the deceased.
2. The level of service provided by the Ministry of Human Resorces under similar circumstances.

Provincial Classification Section F-1

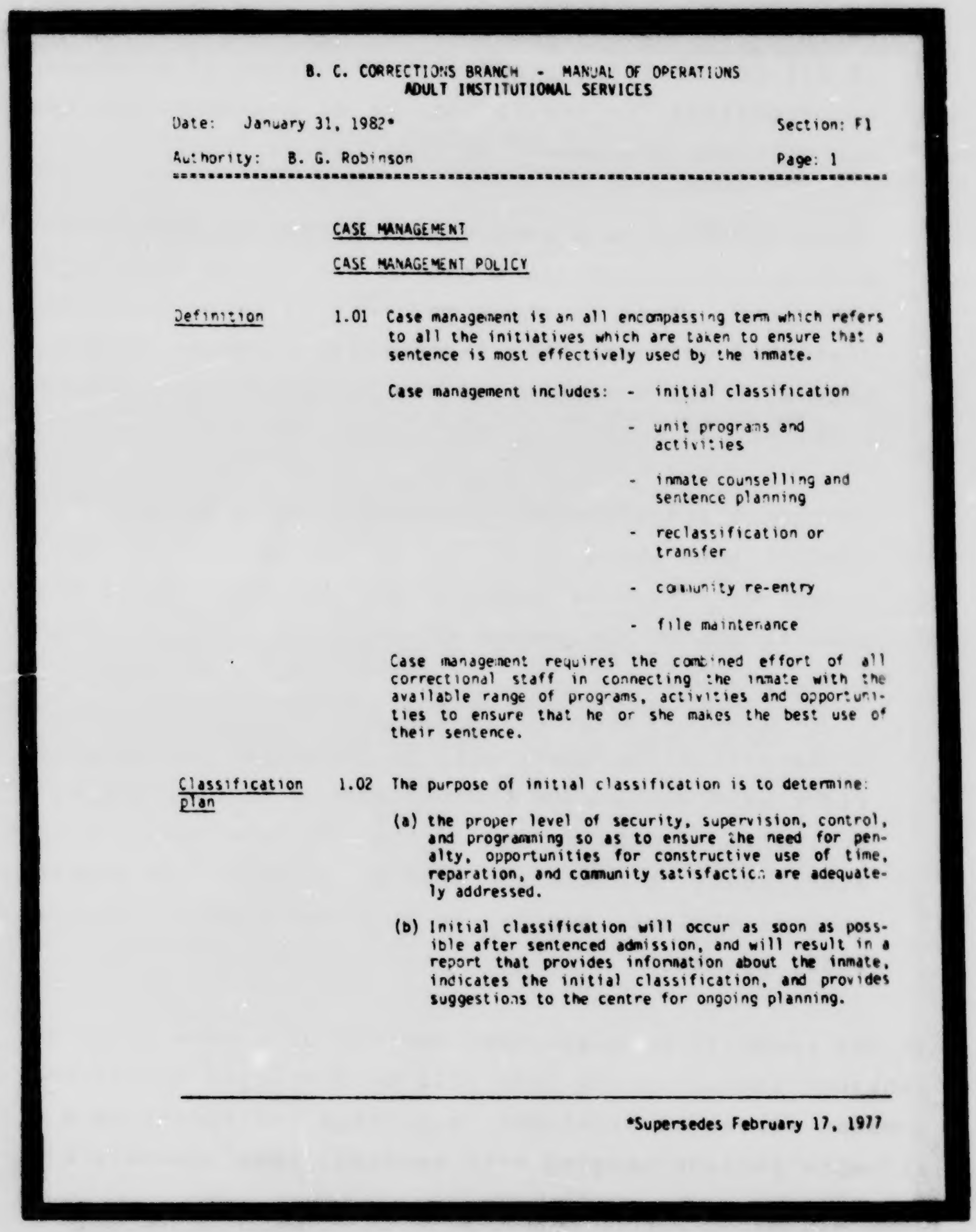
1. Policy that Case Management requires the combined effort of all Correctional staff with the range of programs and opportunities "to ensure that he or she makes the best use of their sentence." (Standard 1.01, pp.1)

2. Classification to a secure institution is made where police information links him to violent or destructive behaviour, where he shows evidence of being emotionally disturbed or where "his instability suggests he cannot cope with the anxieties of his situation". (Standard 2.16, pp. 2d & 2f).

3. Emergency transfers are provided to more secure institutions where there is, in the opinion of the Director, immediate jeopardy for the security of the institution or the safety of staff or inmates. (Standard 2.38, pp. 2p)

4. A classification alert will be displayed in the upper right hand section of the offender's history screen and the personal data screen of the IBM Data Terminal to alert staff to check for special "comment" or cautions such as violent, escape, or suicidal alert. (Standard 2.53, pp. 2t).

It was recently proposed that instead of a mere code, a sentence including the code will be displayed across the comment screen to highlight, e.g. this individual is a - SU, attempts include hanging with bedding. (See Appendix K).



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CASE MANAGEMENT

CASE MANAGEMENT POLICY

Definition

1.01 Case management is an all encompassing term which refers to all the initiatives which are taken to ensure that a sentence is most effectively used by the inmate.

Case management includes:
- initial classification
- unit programs and activities
- inmate counselling and sentence planning
- reclassification or transfer
- community re-entry
- file maintenance

Case management requires the combined effort of all correctional staff in connecting the inmate with the available range of programs, activities and opportunities to ensure that he or she makes the best use of their sentence.

Classification plan

1.02 The purpose of initial classification is to determine:

(a) the proper level of security, supervision, control, and programming so as to ensure the need for penalty, opportunities for constructive use of time, reparation, and community satisfaction are adequately addressed.

(b) Initial classification will occur as soon as possible after sentenced admission, and will result in a report that provides information about the inmate, indicates the initial classification, and provides suggestions to the centre for ongoing planning.

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*Supersedes February 17, 1977

*** Revised August 15 1983**
(content this page unchanged)

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PROVINCIAL CLASSIFICATION POLICY- cont'd

2.12 Inmate transfers between institutions should be held to the minimum.

2.13 Unless they are assigned to special programs that prevent it, inmates should be assigned to centres as close to their homes as security levels and bed space permit.

2.14 The normal procedure will be to assign inmates within geographic areas, rather than to distant centres. However, each centre should be viewed as a provincial resource to which an inmate from any area can be assigned should their classification, and the best use of the centres, be served.

- - → Criteria for assigning inmates to secure institutions

2.15 An inmate should normally be sent to a secure correctional centre when the following criteria is met:

(a) He is judged to be dangerous to the Community because:

- i) He has a number of convictions for violent offences;
- ii) Police information links him directly to violent and destructive behaviour;
- iii) Professional opinion indicates that he is unpredictable, likely to assault; or
- iv) His violent or agressive behaviour makes him a risk to staff or to other inmates.

(b) He is judged as likely to attempt escape, because:

- i) He has twice attempted escape during his present sentence;
- ii) He has repeatedly attempted escape during present and previous sentences;

* Revised August 15,1983
(2.15 now listed 2.16)

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PROVINCIAL CLASSIFICATION POLICY- cont'd

(e) A medical or psychological assessment is needed to help classify him, because:

- i) He has a background of instability, suggesting that he may be violent;
- ii) He appears to have social or intellectual deficiencies that make placement difficult;
- - - → iii) He shows evidence of being emotionally disturbed, or
- iv) He has a mental or physical condition that requires hospital care.

(f) He has other legal matters pending, such as other criminal charges, or an immigration hearing. He should be assigned to a secure centre if:

- i) The outstanding Court matters are more serious than the ones for which he is serving a sentence,
- ii) He has been remanded in custody on these matters;
- iii) He has a pattern of failing to appear at court that shows disregard for court-imposed sanctions;
- iv) The details of the outstanding matters are not clear;
- v) He is under investigation for a crime, but not yet charged;
- - - → vi) His instability suggests that he cannot cope with the anxieties of his situation;
- vii) He needs to be readily available for legal counsel;

*** Revised August 15, 1983**
(lettering changed but not content)

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PROVINCIAL CLASSIFICATION POLICY (Continued)

Emergency transfers

2.38 If, in the local director's opinion, the security of an open or community correctional centre is in immediate jeopardy, or the safety of the staff, the inmates, or the community are threatened by the conduct of an inmate, the director may transfer that inmate to the nearest secure correctional centre. He will advise the secure centre by telephone before the inmate arrives. The director will arrange for a written report of the incident to be placed in the inmate's file, and for a copy of the report to be sent to Provincial Classification within 24 hours.

2.39 A medical emergency may make an emergency transfer necessary. In that case, copies of the report to the inmate's file will be sent both to Provincial Classification and to the Senior Medical Officer.

2.40 Any correctional centre that undertakes an emergency transfer will notify the Director of Provincial Classification, or his delegate, before 9:00 a.m. the next working day.

2.41 The Director of Provincial Classification will review all emergency transfers to confirm that the inmate is receiving the most appropriate treatment. He will prepare a quarterly analysis of emergency transfers that will be reviewed with Branch management.

The classification procedure

2.42 The purpose of the classification interview is to determine the proper level of security, supervision and control for each inmate, so that the constructive use of the inmate's time, and the need for reparation, and the community's satisfaction, are all properly addressed. The interview will include:

1. A review of the offender's file and of the other written material available, including recommendations from judges and probation officers.
2. The inmate's verification of the written information, and the addition of any other information he provides.

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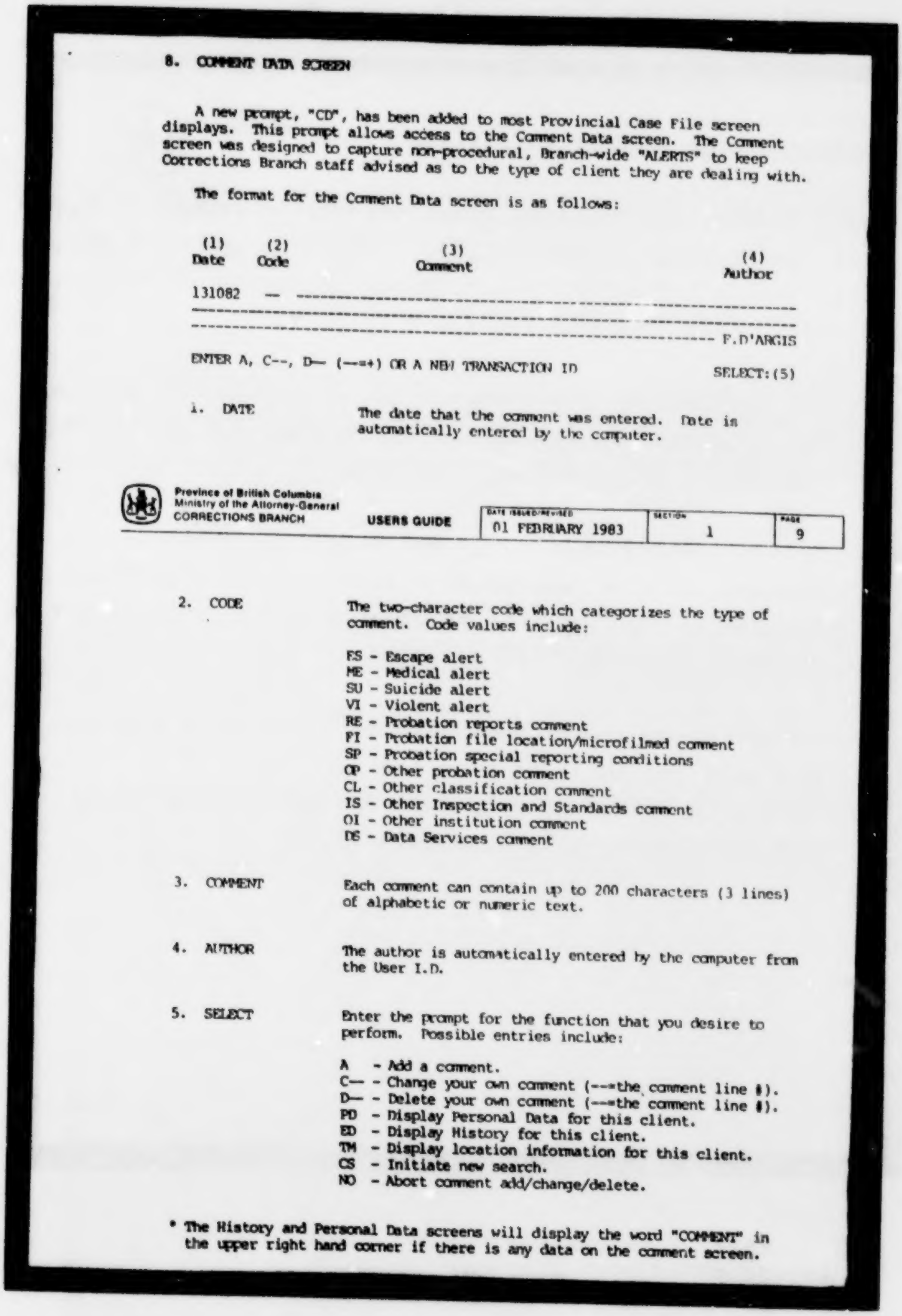
PROVINCIAL CLASSIFICATION POLICY (Continued)

Classification alert

2.53 The letters CA displayed in the upper right hand section of the offender history screen and the personal data screen of an IBM 3270 Terminal indicate that the Director of Provincial Classification should be contacted prior to making a decision that would change that person's level of security.



8. COMMENT DATA SCREEN

A new prompt, "CD", has been added to most Provincial Case File screen displays. This prompt allows access to the Comment Data screen. The Comment screen was designed to capture non-procedural, Branch-wide "ALERTS" to keep Corrections Branch staff advised as to the type of client they are dealing with.

The format for the Comment Data screen is as follows:

```
 (1)     (2)               (3)                                 (4)
 Date    Code            Comment                              Author

131082   --  ----------------------------------------------------------
-----------------------------------------------------------------------
----------------------------------------------------------- F.D'ARGIS

ENTER A, C--, D-- (--=+) OR A NEW TRANSACTION ID            SELECT:(5)
```

1. DATE — The date that the comment was entered. Date is automatically entered by the computer.

2. CODE — The two-character code which categorizes the type of comment. Code values include:

ES - Escape alert
ME - Medical alert
SU - Suicide alert
VI - Violent alert
RE - Probation reports comment
FI - Probation file location/microfilmed comment
SP - Probation special reporting conditions
OP - Other probation comment
CL - Other classification comment
IS - Other Inspection and Standards comment
OI - Other institution comment
DS - Data Services comment

3. COMMENT — Each comment can contain up to 200 characters (3 lines) of alphabetic or numeric text.

4. AUTHOR — The author is automatically entered by the computer from the User I.D.

5. SELECT — Enter the prompt for the function that you desire to perform. Possible entries include:

A - Add a comment.
C-- - Change your own comment (--=the comment line #).
D-- - Delete your own comment (--=the comment line #).
PD - Display Personal Data for this client.
HD - Display History for this client.
TM - Display location information for this client.
CS - Initiate new search.
NO - Abort comment add/change/delete.

* The History and Personal Data screens will display the word "COMMENT" in the upper right hand corner if there is any data on the comment screen.

Service Delivery Standards, Section G-1

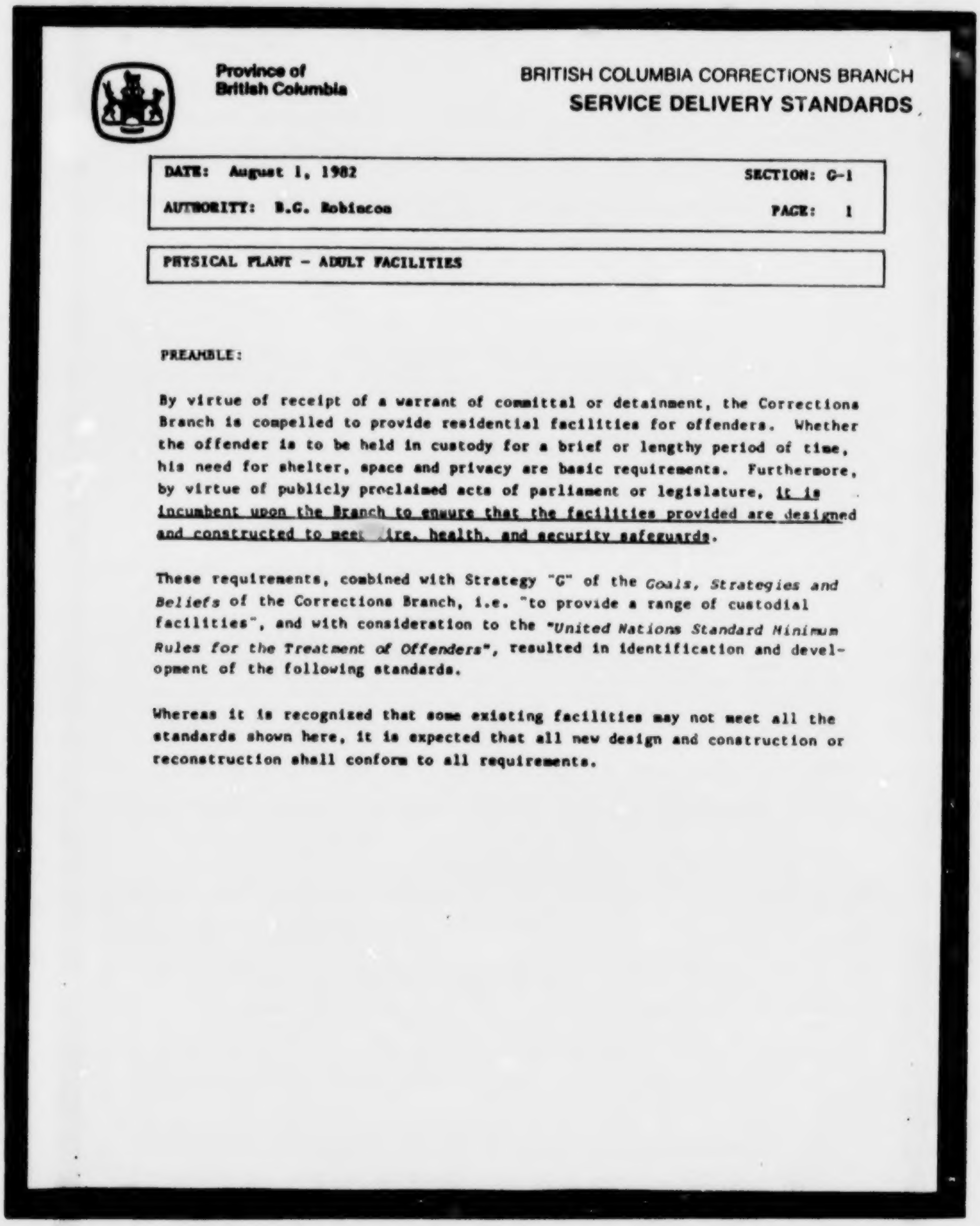
Physical Plant - Adult Facilities

New Standards for Physical Plant were first issued in August 1982, and revised August 1, 1983 addressing the need for fire, health and security safeguards including safeguards for suicide. (See Preamble Section G-1, p. 1)

1. All furnishings and fixtures used in cells for special security containment shall be designed and installed in such a way as to prevent suicides. (Standard 6, p. 4)

2. Secure custody cell doors and security gates must be provided with automatic as well as manual unlocking devices in case of fire or other disaster requiring mass release. (Standard 18, p. 13)

3. Materials for cell construction, furnishing, equipment and painting shall be selected for fire resistent/retardant properties as well as low toxic emmission potential. (Standard 19, p. 14)



Province of British Columbia

BRITISH COLUMBIA CORRECTIONS BRANCH

SERVICE DELIVERY STANDARDS

DATE: August 1, 1982	**SECTION:** G-1
AUTHORITY: B.G. Robinson	**PAGE:** 1

PHYSICAL PLANT - ADULT FACILITIES

PREAMBLE:

By virtue of receipt of a warrant of committal or detainment, the Corrections Branch is compelled to provide residential facilities for offenders. Whether the offender is to be held in custody for a brief or lengthy period of time, his need for shelter, space and privacy are basic requirements. Furthermore, by virtue of publicly proclaimed acts of parliament or legislature, it is incumbent upon the Branch to ensure that the facilities provided are designed and constructed to meet fire, health, and security safeguards.

These requirements, combined with Strategy "G" of the *Goals, Strategies and Beliefs* of the Corrections Branch, i.e. "to provide a range of custodial facilities", and with consideration to the "*United Nations Standard Minimum Rules for the Treatment of Offenders*", resulted in identification and development of the following standards.

Whereas it is recognized that some existing facilities may not meet all the standards shown here, it is expected that all new design and construction or reconstruction shall conform to all requirements.

* Revised August 1, 1983
(content remains unchanged)

Province of
British Columbia

BRITISH COLUMBIA CORRECTIONS BRANCH
SERVICE DELIVERY STANDARDS

DATE: August 1, 1982 **SECTION:** G-1
AUTHORITY: B.G. Robinson **PAGE:** 4

PHYSICAL PLANT - ADULT FACILITIES

6. Every cell/secure sleeping room in a correctional centre shall be equipped, at a minimum, with the following:
   - a) continuously available hot and cold water, servicing a fixed basin;
   - b) toilet designed for the mechanical elimination of human waste;
   - c) artificial light source which is both occupant and centrally controlled;
   - d) a bed frame elevated at least one foot from the floor at the top of the mattress;
   - e) a mattress designed in specific recognition of fire dangers in secure settings;
   - f) a table and chair designed to compliment each other;
   - g) 3 square feet of fixed self space;
   - h) 3 fixed clothing hooks;
   - i) direct natural light source comprising at least 8% of the exterior wall area, or 6% of the ceiling area.
   - j) all furnishings and fixtures utilized in cells or security rooms used specifically for special security containment shall be designed and installed in a manner to prevent user suicide and to provide safety measures to all individuals.

[subject to resource availability]

Discussion:

The above standard specifies minimum cell contents - it does not preclude additional construction details or furnishings. Compliance with subsection i) requires new construction in most instances.

18. In secure custody centres all cell doors and movable security gates or barriers shall be designed and built as to facilitate:
   - a) manual and electrical locking and unlocking operations at each individual door, gate or barrier;
   - b) simultaneous manual or electrical locking and unlocking operations of specific doors throughout every living unit.

[subject to resource availability]

Discussion:

The standard addresses the necessary mass release of all inmates and staff, for instance, in the event of fire or earthquake damage to any one system.

Where a mass release of inmates is necessary, the release should be from one secure setting to another.

Simultaneous mass release mechanisms must be operable from remote and secure locations, only.

19. **Materials used in the construction, furnishing, equipping and painting of cells/secure sleeping rooms in secure custody correctional centres shall be selected, in addition to any other criteria, for their fire resistant and/or fire retardant properties, as well as their low toxic emission potential.**

[effective immediately]

Discussion:

Rather than being phrased in terms of "ignition temperature", "parts per million" and other technical terms, the standard strives, in lay language, to emphasize the necessity to build and furnish cells with materials selected in response to the danger of fire in locked space.

Health Care Policy of B.C. Corrections Branch

1. Intake Screening

Procedure for the development of an intake screen for the proper assessment of physical and mental health, with a view to identifying self-destructive behaviour, is set out in this policy (policy 3.1 and 140).

2. Decision Making - Psychiatric Patients

To respond to the special needs of inmates designated as having psychiatric illness, consultation will be required in a matter of assigning housing, program, discipline and transfers. (policy 112 and 113).

3. Medical Administration Training

Training for the administration and distribution of medications will be covered in the new policy and procedure guidelines for training personnel. (Policy 127)

4. Procedure For Provision Of Emergency Services (Plan Logistics and Personnel)

Are to be spelled out in institutional policy with a view to providing fast effecient emergency care (Policy 154)

3.1 Intake Screening

Procedures will be developed to ascertain the individual state of health of every inmate entering our system. The procedure will be twofold - the assessment proper, where we will make sure that the individual state of health of an inmate is not a menace to himself or to others already in the system, and a procedure to ensure that throughout our system and for the length of his stay, the inmate will know the proper procedure for accessing health care.

Receiving Screening

140 Written policy and defined procedures require receiving screening to be performed by health trained or qualified health care personnel on all inmates newly arrived at the facility with the findings recorded on a printed screening form approved by the health authority. The screening includes at least:

Inquiry into:
- Current illness and health problems including venereal diseases;
- Medications taken and special health requirements;
- Use of alcohol and other drugs which includes types of drugs used, mode of use, amounts used, frequency used, date or time of last use and a history of problems which may have occurred after ceasing use (e.g., convulsions); and
- Other health problems designated by the responsible physician.

Observation of:
- Behavior, which includes state of consciousness, mental status, appearance, conduct, tremor and sweating;
- Body deformities, ease of movement, etc.
- Condition of skin, including trauma markings, bruises, lesions, jaundice, rashes and infestations, and needle marks or other indications of drug abuse.

Disposition to:
- General inmate population; or
- General inmate population and later referral to appropriate health care service; or
- Referral to appropriate health care service on an emergency basis.

(ESSENTIAL)

Discussion: Receiving screening is a system of structured inquiry and observation designed to prevent newly arrived inmates who pose a health or safety threat to themselves or others from being admitted to the facility's general population and to rapidly get newly admitted inmates to medical care. Receiving screening can be performed by health personnel or by a trained correctional officer at the time of admission.

Facilities which have reception and diagnostic units and/or a holding room must conduct receiving screening on all inmates upon arrival at the facility, as part of the admission procedure. In short, placing two or more inmates in a holding room pending screening the next morning fails to meet compliance.

Decision Making -- Psychiatric Patients

112 Written policy requires consultation between the facility administrator and the responsible physician or their designees prior to the following actions being taken regarding patients who are diagnosed as having a psychiatric illness:

Housing assignments;
Program assignments;
Disciplinary measures;
Transfers in and out of institution.

Discussion: Maximum cooperation between custody personnel and health care providers is essential so that both groups are made aware of movements and decisions regarding psychiatric patients. Psychiatric problems may complicate work assignments or disciplinary management. Medications may have to be adjusted for safety at the work assignment or prior to transfer.

Transfer of Patients With Acute Illnesses

113 Written policy and defined procedures require that patients with acute psychiatric and other serious illnesses as defined by the health authority, who require health care beyond the resources available in the facility, are transferred or committed to a facility where such care is available.

Discussion: All too often seriously ill inmates have been maintained in correctional facilities in unhealthy and anti-therapeutic environments. The following conditions should be met if treatment is to be provided in the facility:

1) Safe, sanitary, humane environment as required by sanitation, safety and health codes of the jurisdiction.
2) Adequate staffing/security to help inhibit suicide and assault, i.e., staff wihin sight or sound of all inmates.
3) Trained personnel available to provide treatment and close observation.

Medication Administration Training

127 Written policy and defined procedures guide the training of personnel who administer or distribute medications and require:
- Training from the responsible physician and the facility administrator or their designees.
- Training regarding:
    - Accountability for administering or distributing medications in a timely manner according to physician orders; and,
- Recording the administration or distribution of medications in a manner and on a form approved by the health authority.

(ESSENTIAL)

Discussion: Training from the responsible physician encompasses the medical aspects of the administration or distribution of medications; training from the facility administrator encompasses security matters inherent in the administration or distribution of medications in a correctional facility.

The concept of administration or distribution of medications according to orders includes performance in a timely manner.

Please refer to Standard 163 for the definition of administration or distribution of medications.

Emergency Services

154 Written policy and defined procedures require that the facility provide 24-hour emergency medical and dental care availability as outlined in a written plan which includes arrangements for:

Emergency evacuation of the inmate from within the facility;
Use of an emergency medical vehicle;
Use of one or more designated hospital emergency rooms or other appropriate health facilities;
Emergency on-call physician and dentist services when the emergency health facility is not located in a nearby community; and
Security procedures that provide for the immediate transfer of inmates when appropriate.
(ESSENTIAL)

Discussion: Emergency care must be provided with efficiency and speed.

B. SUICIDE POLICY QUESTIONNAIRE

Forty questionnaires (Appendix J) designed to tap the existing written local policy throughout the Branch, netted wide response but reflected that few facilities have written policies concerning:

a) the identification of potential suicides,
b) special observation surveillance procedures,
c) training of staff respecting a) and b), and
d) medical or other special procedures for these incidents.

In fairness, the great majority of Branch facilities, particularly the many open settings, have never had an incident of self-inflicted injury or a suicide attempt to even sensitize staff or bring these issues to the fore.

In secure settings where written policy does not exist, we realize that most officers nevertheless have completed Branch Training Programs and have had the benefit of on-the-job training experience with officers, many of whom have previously dealt with these types of incidents.

Responses to the questionnaire are listed here with originals found on page 162, a to m.

1. P.G.R.C.C. "Procedures to Combat Attempted Suicide", Nov. 23, 1981.

2. Jordan River, "2.02 Suicide or Attempted Suicide."

3. Centre Creek Camp, "Code Four Suicide".

4. C.C.C.#1, (VIRCC), "Policy on Suicides or Attempted Suicides", April 29, 1982.

5. Boulder Bay Camp, "Suicides - General", April 22, 1982.

6. Victoria Youth Detention Centre, "Policy #63 Critical Incident: Suicide, Assault", April 1, 1982.

7. Willingdon Youth Detention Centre, "Policy #9, Suicide Attempts", April 20, 1981.

8. Chilliwack Forest Camps, "Colour Tagging Identification System", Nov. 24, 1981.
   "Reporting Accidents", February 5, 1982.

9. LMRCC "Colour Tagging Inmate Files", Nov. 10, 1981

EVALUATION:

We recognize that in the absence of local written institutional policy, we have in the past still been reasonably well served with the Justice Institute's Training Programs, the Procedure Manuals themselves, but in the main, the on the job training and exprience of our Branch staff officer.

A great deal of pragmatic experience and informal training has taken place over the years in our Correctional Institutions as officers encountered these problems and learned through trial and error what works or doesn't work.

Our aim throughout this project, to synthesize existing knowledge and procedure, must now move from our tabulation of the foregoing written policies to tap the wisdom and experience of staff officers through seminars and information sharing sessions to come up with the best most pragmatic suggestions for a Branch suicide prevention program which will be incorporated into staff training and Manual of Standards.

APPENDICIES

APPENDIX A

SUICIDE/ATTEMPTED SUICIDE STATISTICS 82-07-12

NAME: ______________ **#** ________ **INSTITUTION:** ____________

DESCRIPTION:

Age: ________ D.O.B.: __________ Sex: ______

Personal Description - Height: ________ Weight: ________ Build: ____________

Special physical characteristics: ______________________________

____

STATUS:

Remand [ ] Sentenced [ ] Details: ______________________________

____

Unit: Maximum [ ] General Population [ ] Segregation [ ]

Other: ______________________________

Adjustment In Unit: Non Cooperative [ ] Cooperative [ ] Aggressive [ ]

Assaultive [ ] Social Withdrawal [ ] Fearful [ ]

Other [ ] Trouble Sleeping [ ] Bizarre Behaviour [ ]

Date Admitted: ______________________________

Time Served Since Admission: ______________________________

Stage of Sentence: ______________________________

Sentence Length: ______________________________

Time Served in Present Location: ______________________________

Transfers: ______________________________

____

OFFENCE/CRIMINAL HISTORY:

F.P.S. # ______________

Offence/Current Charges: ______________________________

____

____

Types Of Offence: Against Person [ ] Against Property [ ] Drug Related [ ]

Major Pattern (underlined) Escape [ ] Sex Offender [ ] Alcohol Related [ ]

Criminal History: ______________________________

____

____

____

FAMILY BACKGROUND:

Place of birth: ______________ Ethnic Origin: ______________

Nationality: ______________ Religious Activity: ______________

History Of Suicide In Family: ______________________________

Intelligence Quotient (Estimate): __________ Education: ______________

Occupation: ______________________________

Work History: ______________________________

____

____

Sexual Orientation: ______________________________

Marital Status: Single [ ] Married [ ] Common-Law [ ] Widowed [ ]

Separated [ ] Divorced [ ] Not Stated [ ]

Family History: ____________________

TREATMENT HISTORY:

Medical Problems: ____________________

Medication: ____________________

Abnormalities - Psychological: ____________________

Sociological: ____________________

Cultural: ____________________

Alcohol History: ____________________

Drug History: ____________________

Previous Threats: ____________________

Previous Attempts - When: __________ Seriousness: __________

When: __________ Seriousness: __________

CURRENT SUICIDE/ATTEMPT:

Location Of Suicide Attempt: Cell # ______ Tier ______

Date: Day [ ] Month [ ] Year [ ] Day of Week: __________

Who Discovered: __________ Time Discovered: __________

Last Time Checked: __________ Official Time Of Death: __________

Method: ____________________

Implement Used: ____________________

Motives: ____________________

Behavioral Indicators: ____________________

Staff Aware [ ] Inmates Aware [ ] Family Aware [ ] Suicide Note [ ]

Unusual Characteristics: ____________________

EMERGENCY RESPONSE:

Emergency Responses By Staff - Administered [ ] No Treatment [ ] Not Stated [ ]

Details: ____________________

CORONER'S INQUEST

LOCATION ____________________ DATE __________

AUTOPSY REPORT ____________________

AUTOPSY REPORT CONCLUSIONS ____________________

ALCOHOL OR DRUGS PRESENT ____________________

FINDINGS - No Blame [ ] No Comment [ ]

Exonerates Staff/Institution [ ]

Finds Fault Staff/Institution [ ]

RECOMMENDATIONS: NO RECOMMENDATIONS [ ]

ACTION TAKEN:

DATA DRAWN FROM:

Signature: __________

MINISTRY OF ATTORNEY GENERAL CORRECTIONS BRANCH — 05 Octob. 981

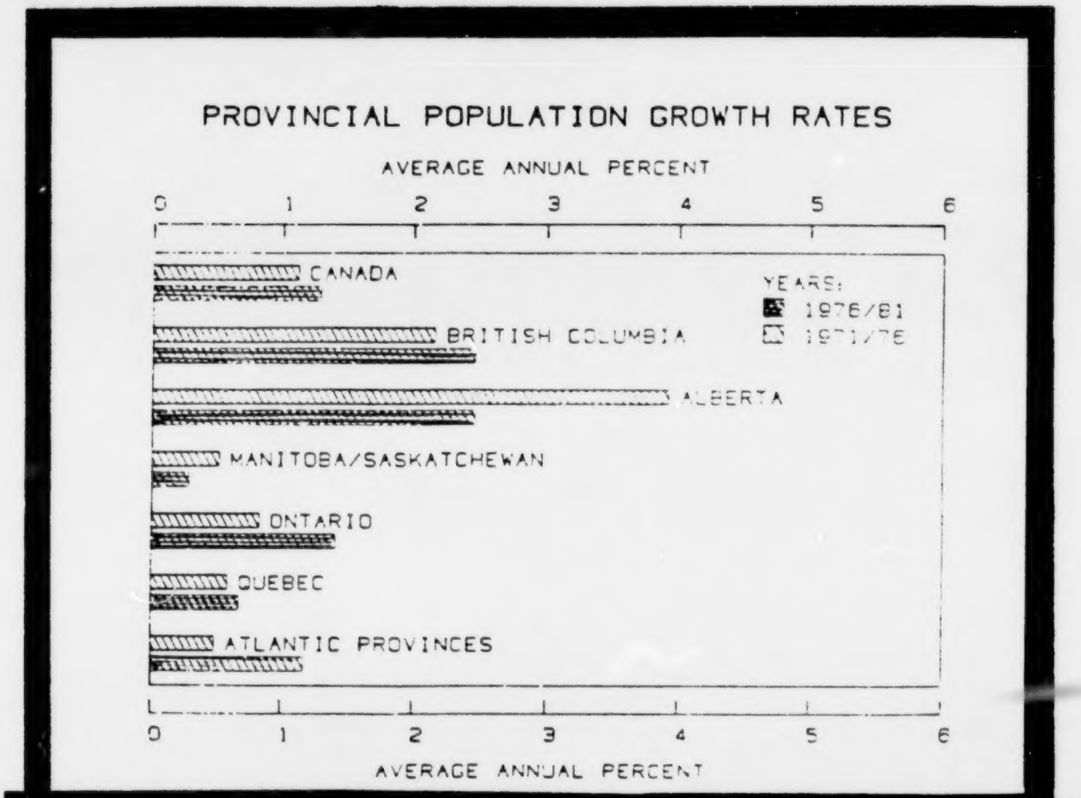
ADULT INSTITUTIONS

Percent of Admissions and Average Count by Selected Categories

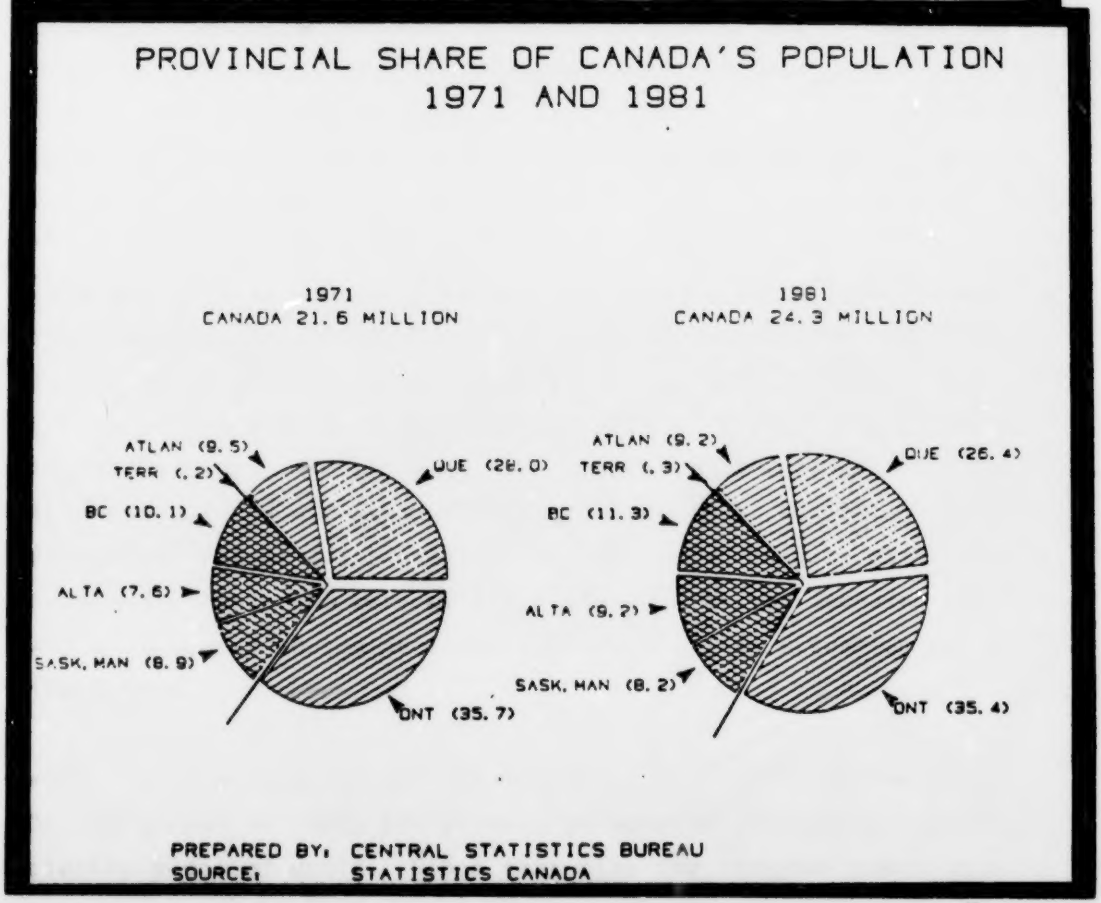
APPENDIX B

CATEGO	SENTENCED								REMAND							
	1978/79		1979/80		1980/81		3-yr trend		1978/79		1979/80		1980/81		3-yr trend	
	Adm.	Aver. Count	Adm.	Aver. Count	Adm.	Aver. Count	Adm.	Aver. Count	Adm.	Aver. Count	Adm.	Aver. Count	Adm.	Aver. Count	Adm.	Aver. Count
AGE																
Under 18	3.6	2.8	3.1	2.2	3.5	3.0			6.3	3.4	5.9	3.6	6.1	3.9		+
18-19	12.9	14.9	13.4	15.6	11.9	16.6		+	14.5	11.5	15.3	14.6	15.4	11.8		
20-21	12.3	16.1	12.4	13.7	13.7	15.7	+	+	13.2	9.5	12.6	10.7	13.3	13.4		+
22-24	15.9	17.2	16.0	17.7	16.0	16.4			16.3	15.9	17.1	15.4	15.5	16.2		
25-29	17.6	18.4	17.8	17.7	18.1	18.3	+		18.1	18.2	18.7	21.6	18.3	21.2		
30-34	12.2	10.8	11.7	12.9	12.5	10.6			12.0	17.9	11.8	14.7	12.5	14.4		-
35-39	8.0	7.2	8.4	7.0	8.1	7.4			7.5	8.2	7.6	6.7	7.7	7.7		
40-49	10.9	8.3	10.0	8.1	9.6	7.5	-	-	6.9	10.2	6.9	7.7	7.0	7.8		
50 +	6.5	4.3	7.2	5.2	6.6	4.5			5.1	5.3	4.2	4.9	4.3	3.7		-
SEX																
Male	92.8	93.5	95.4	94.1	95.2	95.6		+	91.4	92.9	92.2	94.7	94.3	94.8	+	+
Female	7.2	6.5	4.6	5.9	4.8	4.4		-	8.6	7.1	7.8	5.3	5.7	5.2	-	-
RACE																
Native	16.9	16.4	18.8	17.6	17.7	18.6		+	16.6	15.1	17.7	20.0	15.0	17.7		
Non-Native	83.1	83.6	81.2	82.4	82.3	81.4		-	83.4	84.9	82.3	80.0	85.0	82.3		
SENTENCE LENGTH IN DAYS																
1- 7	8.7	1.1	8.2	1.0	7.4	.7	-	-	N/A	N/A	N/A	N/A	N/A	N/A		
8- 14	21.7	3.5	20.6	3.0	18.5	3.1	-		N/A	N/A	N/A	N/A	N/A	N/A		
15- 21	8.3	2.0	8.7	1.8	8.5	1.8			N/A	N/A	N/A	N/A	N/A	N/A		
22- 30	15.4	4.8	15.2	4.9	16.1	5.4		+	N/A	N/A	N/A	N/A	N/A	N/A		
31- 45	2.2	.9	2.0	.9	1.9	.9	-		N/A	N/A	N/A	N/A	N/A	N/A		
46- 60	6.2	4.7	5.8	3.6	6.6	4.8			N/A	N/A	N/A	N/A	N/A	N/A		
61- 90	9.8	9.4	11.0	9.7	10.5	9.9		+	N/A	N/A	N/A	N/A	N/A	N/A		
91-180	11.4	19.5	12.1	18.3	12.5	18.3	+		N/A	N/A	N/A	N/A	N/A	N/A		
181-270	4.2	11.3	4.5	11.6	5.1	12.1	+	+	N/A	N/A	N/A	N/A	N/A	N/A		
271-360	3.9	14.4	4.3	15.2	4.7	15.8	+	+	N/A	N/A	N/A	N/A	N/A	N/A		
361-719	4.6	23.2	4.3	25.5	4.8	23.8			N/A	N/A	N/A	N/A	N/A	N/A		
720 +	2.9	4.7	3.2	4.0	3.3	3.5	+	-	N/A	N/A	N/A	N/A	N/A	N/A		
Indefinite	.7	.6	.1	.4	.0	.1	-	-	N/A	N/A	N/A	N/A	N/A	N/A		
Actual number of admissions/count	7151	1290	7032	1301	6856	1138			4319	383	4423	359	4441	358		

APPENDIX C



PROVINCIAL POPULATION GROWTH RATES



PROVINCIAL SHARE OF CANADA'S POPULATION 1971 AND 1981

PREPARED BY: CENTRAL STATISTICS BUREAU
SOURCE: STATISTICS CANADA

[illegible]

Paul E. Termansen, M.D. F.R.C.P.(C)
Clinical Associate Prof.
U.B.C. Medical School, Dept. of Psychiatry
Chief of Psychiatry, Lion's Gate Hospital

APPENDIX D

THE PSYCHOLOGICAL AUTOPSY

The psychological autopsy is a procedure which attempts to clarify the nature of death through a socio-psychological focus on life immediately prior to death. Historically, the certification and data gathering processes relevant to death recognize five modes of death. The five modes of death are distinct from causes of death which are many and varied. The five modes of death are:

1. Natural
2. Accident
3. Suicide
4. Homicide
5. Undetermined

The cause of death does not necessarily reveal the mode of death. A death certificate stating, for example, the cause of death to be asphyxiation due to drowning does not indicate whether the mode of death was accidental and that the deceased struggled and drowned or whether the deceased intended to drown and deliberately entered the water. The certification does not state either whether the victim was held under the water until drowned, indicating a homicide.

In a significant number of deaths the mode of death is not clear. These deaths are called equivocal deaths. The main purpose of a psychological autopsy is to clarify the equivocal death and to arrive at the most possible accurate mode of death. The psychological autopsy is a thorough, retrospective investigation of the intention of the deceased with respect to his or her being dead. The psychological autopsy bases its conclusion on data gathered from individuals who were well acquainted with the deceased and who will report on the deceased's behavior, life situation and character.

When the term "psychological autopsy" was initially coined by Dr. Shneidman in 1958, the primary purpose of the autopsy was to clarify modes of death. Since that time the term has taken on a broader meaning and the procedure of psychological autopsy is now used to clarify the following questions:

1. Why did the individual do it? When the mode of death is clearly suicide, the autopsy can assist in determining the reason for the act or reconstructing the motivations, attitudes towards life and death of self and others and the crises preceding death.
2. How did the individual die, and why, at that particular time? When the individual is dying gradually over time, the psychological autopsy may illuminate the socio-psychological reasons why the individual died at that particular time. There is little doubt that frequently there is a connection between the psychological state of the individual and the time of death, even though such connection may be difficult to establish.
3. What is the most probable mode of death? When the cause of death can be clearly established, but the mode of death remains equivocal, the psychological autopsy can assist in establishing the mode of death with greater accuracy.

The Procedure of Psychological Autopsy

There is no fixed procedure for carrrying out a psychological autopsy. The main purpose of the autopsy is to gather psychological sociological and medical data relevant to the mode of life and death of the deceased being autopsied. In general, the data is gathered from key persons who knew the deceased. The data is gathered through telephone conversations and direct interviews preferably in the home setting of the relatives and close friends. Anyone doing psychological autopsies, or autopsies in general for that matter, must be acutely aware of the emotionally laden nature of any of the questions that may be posed. Furthermote, anyone close to the deceased is experiencing grief and the autopsy should always proceed with the mental health of the survivors in mind.

The following categories should be considered when doing a psychological autopsy:

1. Identification
    a) Name
    b) Age
    c) Sex
    d) Marital Status
    e) Residence
    f) Religious Practises
    g) Employment Status

2. Details of Death
    a) Cause
    b) Method
    c) Time
    d) Place

3. Brief History
    a) Life situation immediately prior to death
    b) Past history, medical and psychiatric, including psychiatric treatment, hospitalizations and previous suicide attempts
    c) Background History

4. Death History of Victim's Family

5. Personality and Lifestyle of the Deceased

6. Typical Reactions to Stress

7. Life Crises During the Past Five Years

8. Role of Drugs or Alcohol in Normal Lifestyle as well as in Bringing About Death

9. Nature of Interpersonal Relationships

- APPENDIX E -

"CORRECTIONS MAGAZINE"
August 1981

Suicide In the Cellblocks

In N.Y., Inmates Keep the Suicide Watch

IN many jails where officials can't afford the training and staff for a suicide prevention program, veteran correction officers rely on the inmates to police themselves. Officers say that some inmates who have been in jail many times often have an uncanny ability to pick out what they call the "strangers" — those inclined to do themselves in.

In some jails, inmate trusties are designated to do nothing else but keep a watch on their suicidal fellows. The most formal program of this kind is in New York City, where 150 "suicide prevention aides" are paid by the Department of Corrections to monitor the jail complex on Rikers Island and jails in the Bronx and Brooklyn.

The program was started in 1972 after a rash of suicides. Until recently, the suicide aides were simply chosen and told to watch the other inmates, without any formal instruction as to exactly what they were to do. Last year, John Rakis was hired to create a comprehensive suicide prevention program, and he has set up a training program for the aides. John Herbert, a veteran correction officer, now teaches an eight-week course for the aides, in which he describes the danger signs and instructs the aides on what to do in case of a suicide attempt. Thus far, says Herbert, the aides have been inquisitive and glad to receive the training.

The most serious problem with the program, according to Rakis, is that there isn't enough money. Aides are paid 15 cents to 35 cents an hour, which adds up to about $75,000 a year for the entire program. For this the aides walk the tiers eight hours a day, with instructions to talk to other inmates and report any change of behavior to the officers.

John Cunningham, warden of Brooklyn's House of Detention for Men, says he is impressed with the suicide aide program. "We need all the help we can get," he says. "Death is such a speedy thing."

Aides in Cunningham's jail complain that one of the biggest problems is getting cooperation from the officers.

Sitting in a "meeting" cell in the "psych wing," six aides told tales of officer disinterest and laziness. Role-playing in class, they said had given them some understanding of the officers' problems, but the officers just didn't seem to want to understand theirs. "We just don't get no respect from them," claimed one man in on a robbery charge. "One guy asked me to mop the floor while I was on duty."

"Still," added another, "it's a lot better since 1978. Right now, my life ain't so hot. I'm confined. There's pressure about my trial. But with this, I can try helping someone else."

Of the six, three said they had actually stopped suicide attempts and most agreed that working with "bug-eyes," as they called the inmates in the psych wing, made them feel better off.

As the talk went on, the noise on the tier grew to a roar. Finally, the leader of the aides called out of the cell, "Ice it." The tier fell silent.

The incident illustrated that the suicide aides had made themselves powerful. This power worries some officers, who, off the record, complain that the aides in a good position to blackmail other inmates and to pass contraband.

Rakis counters that other jobs also put inmates in a position of power and that, in this case, it's worth the risk. Michael Austin, director of the city Board of Correction, agreed. "Right now, we've tremendous numbers of people coming in. The suicide aide program can help, if it's monitored correctly."

While there are no figures on just how many suicides are prevented by the aides, one thing is clear: The program obviously helps the aides themselves, men like Angel. Angel was interviewed while awaiting trial for the alleged attempted murder of his wife. Other inmates say that after the domestic dispute he tried to kill himself. Angel says he has stopped two people from "cutting up" and one from hanging. "I came to this job in a bad way," he says. "I really need this job to keep occupied. I know what it's like, to be without hope. That's what I try to pass on to the brothers here: If you have hope, you won't hurt yourself." ☐

CRIMINAL JUSTICE NEWSLETTER

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THE NATIONAL COUNCIL
ON CRIME AND DELINQUENCY

*A Bi-Weekly Report on Significant Developments
For Leaders in Criminal Justice Administration*

CORRECTIONS

SUICIDE PREVENTION PROGRAM STARTED IN FEDERAL PRISONS

Guidelines and Treatment Outlined

The Bureau of Prisons has established a program and set guidelines to curb suicides and observe potentially sucicidal inmates in federal prisons.

"While such occurrences as suicide attempts cannot be totally eliminated, the Bureau of Prisons is responsible for monitoring the health and welfare of individual inmates, and for ensuring that procedures are pursued to help preserve life," the Bureau said in its final rules, published in the June 23 issue of the Federal Register.

The Suicide Prevention Program, which goes into effect July 26, requires wardens to designate in writing a full-time staff member — usually the institution's chief psychiatrist or chief psychologist — to serve as program coordinator.

Staff Procedures

The coordinator's duties will include overseeing the training of staff members to observe and understand behavior of potential suicides, to refer those persons to the coordinator, and to place documentation of the referral in the inmate's medical file.

After receiving a refe[illegible], the coordinator is to begin what are called "crisis intervention techniques," which involve meeting with the inmate, exhibiting a sincere concern for his or her welfare, and assuring that the inmate is not left unattended.

If the coordinator determines that the inmate is not suicidal, the reasons for this decision are to be put in writing and placed in the inmate's medical file along with the initial referral.

If the inmate is considered to be a potential suicide, say the guidelines, the coordinator, will immediately arrange for the inmate to be put under constant observation. The guidelines also urged that other techniques could be used, such as increasing the inmate's contact with staff members with whom the inmate has a positive relationship, reassignment of the inmate to another housing facility and providing treatment services.

— —➤ Inmates as Monitors

Another aspect of the program is that selected inmates are to be trained as "companions," whose role will be to monitor potentially suicidal inmates when sufficient staff are unavailable. Companions may have visual and verbal interaction, but no physical contact with the potentially suicidal inmate, the Bureau said.

The guidelines say that companions are not to be considered hospital workers, but that they will receive compensation for their monitoring time. This could take the form of performance pay, a Bureau spokesman said.

Province of British Columbia
Ministry of Attorney General
CORRECTIONS BRANCH

MEMORANDUM

- APPENDIX F -

To: L. Linn
Director
Administration

Date: 26-1-82

Re: Orientation for first offenders on admission to LMRCC

I would like to submit for your consideration a proposal to implement a program whereby all offenders who are being admitted to LMRCC would receive a short orientation while in the records area. I am listing below some of the areas I anticipate would be covered in the orientation and some of the possible benefits.

1. It would be explained to the inmate just what his status is in the court system if he is still waiting trial, i.e. future court date if any, information on bail. These are two areas that are most often addressed by the inmates when they are admitted. We would however respond to any particular concern regarding the court system, judicial release or any other question concerning movement and custody.
2. For inmates who are sentenced we would provide information regarding release dates and parole eligibility as well as information on release programs. We would also provide some information about the classification process although of course we would consult with classification as to their requirements in such a program.
   Information regarding appeals would also be included.
3. All other areas of concern to the inmate would be responded to e.g. waiver in of charges, visits etc.
4. I anticipate that providing such a service would benefit the receiving units in a number of ways e.g. a reduction in the number of requests both written and oral, a reduction in the frustration level that many new offenders feel having just been arrested and put through the court system and placed with us.
5. It would give us the opportunity to identify those offenders whose emotional state might be such that they could become a problem for the receiving unit. These offenders would be identified to the appropriate persons in the units for possible interview.
6. While we provide some written material upon admission it has long been felt by our department that although helpful to a point it does not really meet the need and cannot compare to a personal approach, also most of the most common concerns are not covered in the handouts.
7. It would provide staff in the records area the opportunity to increase their skills in interviewing techniques and interpersonal relationships and training programs in these areas are available through the Corrections Branch Staff Development Division.

cont.

8. I understand that a study is being done at this time on suicide prevention. The benefits identified in points 4 and 5 could be helpful in this regard.

If we were to provide this service I would welcome the input of all units in order that we could meet their requirements.
In conclusion I feel that this service would make the whole admission procedure more professional and would reflect well upon the centre. Having suggested this program however I must add that it would be difficult to implement it with the current admitting hours and staffing. I am prompted to submit the proposal at this time due to the future opening of the Vancouver Pre-Trial Centre when the removal of most of the Vancouver Waiting Trial inmates would result in time being available. If it was felt that a program of this nature should be started sooner we could make the necessary adjustments.

R.J. Pearson
S.C.O. Records Office
l.m.r.c.c.

c.c. H. Bjarnason

- APPENDIX G -

Province of British Columbia
Ministry of Attorney-General
CORRECTIONS BRANCH

MEMORANDUM

Justice Institute of B.C., 4180 West 4th Avenue, Vancouver, B.C. V6R 4J5

To: Vince Cain, Director
Inspections and Standards
Commissioner's Office

Date: February 9, 1982

Re: Suicide Prevention Committee - Review of Training

Attached is information which relates to the present format for training of security officers covering the areas of institutional disturbances and suicide prevention. The present format has been in effect for approximately six months and a similar type of format has been in existence for a number of years on basic training courses. Included in the attached are:

- Appendix A - provides an overview of training for suicide and attempted suicide prevention
- Appendix B - course material made available to security officers
- Appendix C - written material covered during the training session and made available to employees for at-home study
- Appendix D - a portion of an examination covering emotional and institutional disturbances
- Appendix E - an outline of advanced courses offered in crisis intervention

In Block II Basic Training, each security officer participates in a session which covers institutional disturbances, fear, and suicide prevention utilizing the material attached in the appendices. A film entitled "Emotional Disturbances in a Correctional Institution" is shown and for officers working in juvenile settings, the film "Childhood's End" is shown. The session includes both lecture and discussion, distribution of resource materials, followed by a short quiz.

The suicide prevention portion of basic training was reviewed by Dr. Harry Stevens about one year ago and he felt that the content was "on the mark" and thorough.

In addition to the basic training program, three advanced courses are offered each year in "crisis intervention". Approximately twenty security officers attend each advanced course, therefore approximately sixty persons per year are able to take advanced training (see Appendix E for course outline). This advanced course utilizes a variety of resource persons including suicide prevention experts and the course involves experiential learning utilizing simulated situations in which the officer is expected to demonstrate crisis intervention skills when intervening in a potential or actual suicide simulation.

. . . 2

It is my view that the basic training course thoroughly covers the area of suicide prevention and that the advanced courses are available to all employees who are assigned to the course by their supervisors. This, however, may not be enough for the average worker who has not had any refresher training for several years. It would be my recommendation that a refresher training course be made available to every employee at least every two years covering such areas as suicide prevention, first aid and CPR refresher training, firearms refresher training, self-defense refresher training, and emergency procedures refresher training. If funds were available for training relief, a standard could be developed whereby every institutional employee would be required to complete two days of refresher training every two years to ensure they are up to date and current in dealing with crisis situations.

An additional area in which more emphasis could be placed on suicide prevention is in Block IV training. If necessary, an additional one hour of training could be inserted in Block IV training as a refresher type of training. If funds were available to extend the Block II Basic Training for one or two days, it would be possible to include simulations and perception exercises. However, the present three week format does not allow enough time for experiential training.

Two areas of concern which I feel the Suicide Prevention Committee should focus on are unit policies and attitude of supervisors. Firstly, some unit policies may inhibit the immediate response to an actual suicide. It is my understanding that some units require staff to have a backup person present before intervening in a suicidal situation. While this type of policy may provide protection from the manipulative type of suicide attempt, if officers are properly trained, they should be able to make a judgement within seconds as to whether a suicide incident is real or artificial. I suggest we review unit policies in relation to immediate intervention into suicidal incidents.

The second area of concern is attitude of supervisors. I am advised that in almost every discussion of suicide prevention during basic training, a number of officers have indicated that they have notified superiors of potential suicidal situations and have found their comments are ignored or are "laughed at". This type of attitude by superiors does little to motivate newer employees to take the issue of suicide prevention seriously.

I suggest our committee spend some time discussing these issues.

J.E. Laverock, Director
Staff Development Division

JEL/mw
cc: John Lacavera
Vera Bergman

BLOCK II - SECURITY OFFICER BASIC TRAINING

AN OVERVIEW OF TRAINING FOR SUICIDE AND ATTEMPTED SUICIDE PREVENTION

Submitted by: John LaCavera
Staff Development Officer
Justice Institute of B.C.
Corrections Branch

POPULAR MISCONCEPTIONS ABOUT SUICIDE

1. People who talk about suicide won't commit suicide.
2. Suicide happens without warning.
3. The suicide rate is rising steadily.
4. Suicide and attempted suicide are the same class of behavior.
5. Suicide involves only specific socio-economic class.
6. Suicide can be explained fully by sociological factors.
7. In North America suicide is more common anong Protestants than among Catholics.
8. Motives or causes of suicide are always readily established.
9. Only people who are depressed attempt or commit suicide.
10. All suicides are on the basis of the same motive.
11. A person who is in a very ill, even terminal state is not lidely to commit suicide.
12. All suicidal persons are insane.
13. Suicide is inherited.
14. Suicide is related to weather phenomena.
15. Suicide is related to moon phases, sunspots, magnetic storms, and other cosmic influences.
16. Improvement in a suicidal patient means the danger is over.
17. Patients under a doctors care are not a suicidal risk.
18. Only a psychiatrist or mental hospital can prevent suicide.
19. Patients in hospitals, especially mental hospitals, are not a suicidal risk.
20. Suicide can be controlled by making it illegal.

(Class Handout)

SALIENT FACTS ABOUT SUICIDE

The facts listed below were generated from results of many suicidal research reports after a comprehensive review of the literature on suicide was completed. The following list of facts are a synthesis of many of the conclusions arrived at by those who have worked with suicidal problems in the field of corrections.

1. Close to 50% of all suicide reports are received from the high security section in an institution.
2. Most serious attempts and successes occur during the graveyard shift.
3. Suicide attempts tend to occur in an epidemic fashion. Most reports and attempts occur during springtime. Another high period tends to be around the Christmas holiday period.
4. Most serious attempts occur from those who are alleged to have committed serious crimes against a person, for example, murder, rape, sodomy, or other crimes of violence.
5. 1/3 of all homicides are followed by suicide in the Unitied States and in Canada.
6. Male suicides are usually quite violent, i.e. shooting or hanging, whereas female suicides are most often by ingestion of pills.
7. Of those who die by their own hand, men outnumber women 3 to 1. Women, however, make gestures or attempts on their lives 3 times as often as do men. Men, therefore, are a higher risk.
8. Suicide gestures (many go unreported) are 8 to 10 times more frequent than actual suicides.
9. In most successful suicides there is no previous history of attempts being made. Individuals who experience jail as the ultimate cultural shock, for example, university students or successful businessmen, are likely to be prone to suicide. Suicide rates for university students in the United States are 50% higher than for all other youths of a comparable age.

(Class Handout)

Suicidal content in part is offered to Security Officers/Youth Supervisors who undergo the Block II Basic Training Course at Corrections Staff Development Division.

The major session "Institutional Disturbances" covers the following objectives:

1. identify the relationship of fear and institutional disturbances;
2. demonstrate an understanding of the dynamics of hostage takings;
3. identify a potentially suicidal inmate; *
4. demonstrate an understanding of the causes of institutional disturbances.

With respect to the above objective regarding the suicidal inmate, my prime responsibility has been to impart valuable information to officers with the underlying objective of prevention in mind. I do not attempt to dictate internal policy regarding suicide, but rather I confine my presentation to the causes, recognition, and prevention of suicide.

The following information is that which is covered on Block II Basic Training Courses:

SOME CAUSES OF SUICIDE:

The three most discussed causes of suicide are:

1. Fear
2. Depression
3. Hallucination

Some examples of these are as follows:

1. Bad news (sickenss or death at home, rejection by family, an untrue wife, criminal illness, loss of a job or many jobs, or loss of sexual functioning).
2. Homosexual rape.
3. No outside contact inter-personally combined with peer group (inmate) hostility.
4. The rapid and sudden experience of confinement for the first offender.
5. Unexpected sentence of a long duration.
6. Guilt arising from the offence committed or fear generated as a result of inmate displeasure at the nature of the offence.
7. Physical and mental abuse from other inmates of a repeated nature.

....../2

8. Confinement for a long period in an unsentenced status.
9. Isolation for protective purposes.
10. A return to detention/prison.

The above causes are discussed at great length.

THE FEAR OF DEPRESSION GENERATED BY THE ABOVE SITUATIONS:

1. Aggressive activity directed outwards.
2. Aggressiveness gets turned inwards resulting in a shutting down of outside stimulation.
3. Often the person will go into a semi-conscious state when depression gets too intolerable.
4. The cutting off of all life supporting experiences and needs thus allowing the individual to funnel his thinking towards self-murder.
5. This person sometimes quickly reverses this process such that the aggressive feelings turn back in an outward manner resulting in a physical attack on others.

THE SUICIDAL PERSON IS DANGEROUS TO OTHERS INCLUDING HIMSELF/HERSELF:

1. They lose sight of socially ordained rules of conduct for themselves, they also tend to lose the same concern for others.
2. Not infrequently, a suicidal attempt involves injury to innocent bystanders (i.e. fire, gassing, accidents, etc.)

HALLUCINATIONS:

1. Normally experienced by the mentally disturbed inmate/resident.
2. Temporarily or permanently lost touch with reality.
3. At any given time the mentally disturbed inmate has a possibility of being extremely dangerous and this possibility or risk increases the need to confine or restrict this person for prolonged periods of time.
4. Quite often we react to the acutely mentally disturbed by isolating them or reducing the sensory environment. This only tends to heighten their fear resulting in a greater increase in their loss of contact with reality. Generally, this person withdraws and deteriorates even further when deprived of contact with others and a reasonable contact with a supportive environment.

. . . . . ./3

5. Continual withdrawal often leads to a physically acting out behavior towards himself or others.

6. A show of aggression, either of a suicidal nature or murder, is generally a last desperate effort to prove one's self that contact can still be made with reality.

Unfortunately, this last effort may well cost someone his or her life.

CAUSES OF DEATH ATTRIBUTED TO ORGANIC AND PHYSICAL PROBLEMS:

1. drug overdose or withdrawal;
2. flashbacks from previous psychedelic drug experiences;
3. high fever;
4. delirium tremens (for alcoholics).

The above conditions are not thought to induce a person to take his own life, however they present the same danger as suicide because death might result if the individual is left alone and unaided. All too often the incarcerate suffering from some type of physical reaction is left to "sleep it off" without any medical or psychological attention.

Emphasis is placed on the following:

It is of utmost importance that whenever the slightest doubt exists about the nature of a resident's/inmate's problem, every effort should be made to advise medical and supervisory staff as soon as possible. Inaction on the part of an officer in circumstances such as these can prove fatal.

SUICIDAL SYMPTOMS:

The byword for detecting the symptoms of potential suicidal inmates/residents is sensitivity. Since it is very often extremely difficult to determine the signs that precede depression, it is important that correctional personnel be able to identify the signs of depression, in particular, when a combination or exaggeration of several signs of depression exist and potential suicide is possible. The Corrections Officer should look for a combination of the following:

1. loss of appetite;
2. extreme difficulty in sleeping;
3. lethargy or the lack of activity;
4. extreme tenseness, restlessness, or agitation;

....../4

5. lack of concern for others or one's personal hygiene;

6. increased dirtiness;

7. shunning of the company of others;

8. a sudden disinterest in any external stimulation such as recreation, music, reading, television, etc.;

9. confused communication with others.

PHONY SUICIDE ATTEMPTS:

Manipulative suicidal attempts are often attention-getting efforts on the part of the individual:

a) hopefully to increase his contact with others;

b) to obtain medication;

c) possibly to prompt his removal to an area where greater safety from other inmates can be experienced;

d) possibility of a planned escape.

Whenever an attempt is made during the day or before an officer is due to make his rounds, it is possible that the inmate could be manipulating since it would appear that he is purposely trying to be detected by a staff member.

Nevertheless, do not take any attempt at suicide lightly as there have been numerous cases in institutions when would be manipulators made a dramatic attempt in order to get attention and subsequently tragically lost their lives by mistake.

EMPATHY:

The term is important as a way of interacting with inmates regardless of how manipulative they might be. It helps to be able to clearly distinguish between the desire to assist another to become responsible for himself and the desire to sympathize with the other's inability to cope with his present life situation.

PREVENTION OF SUICIDE:

1. Pay attention to abrupt changes in personality with those detained.

2. If possible, ascertain if the individual is experiencing something traumatic, for example, the death of a relative, wife, mother, etc.

....../5

3. If you notice an individual who is manifesting either physical or mental symptoms which suggest a possible suicide, it is extremely important you notify:
    - immediate supervisor
    - fellow workers
    - communicate to other staff on following shifts
    - unit report
    - log

4. Once someone is identified as a possible suicide victim, every caution needs to be taken for the entire duration of the individual's incarceration.

5. If someone is threatening to jump or commit suicide, action that precipitates more fear is rushing the suicide victim and may cause their death.

6. Avoid making sudden moves or doing anything that might be interupted as threatening to the suicidal individual.

7. Attempt to verbally motivate the person in a crisis towards getting in touch with the individual's native will to live.

8. Do not crowd a potential suicidal victim, this could precipitate the actual suicide.

9. Surveillance is an immeasurable tool in reducing the possibility of suicidal attempts.

10. An officer's humaness in relationship with the person in trouble is a most critical part of dealing with a crisis.

11. When a personality clash exists, remember that suicide occurs more often when the victim feels antagonism.

12. Learn how to listen, not only to words but to tone, volume, and other qualities of speech.

13. At any cost, do not argue with the suicidal person in your communication efforts.

Many individuals may not be highly "lethal", that is, they may not be ready to end their lives within minutes. Remember the suicidal inmates you will be dealing with most likely are crying out, or who are trying to manipulate a painful environment the best way they know how. Regardless of your feelings, lower risk inmates need intervention. There isn't any effort too great in order to save a human life.

SUMMARY

The presentation regarding suicide is approximately one hour. However, due to the nature and critical importance of the material, I do not restrict myself in terms of time. Generally the duration of the session is entirely dependent upon discussion both during and after the presentation.

At the outset I emphasize our responsibilities in terms of carrying out the sanctions of the court and keeping offenders safe as major priorities. In addition, heavy emphasis is placed upon suicidal symptoms, manipulative attempts, potential victims, prevention and communicating observations.

I have experienced those few who take attempted suicide or suicide for granted. I approach this area professionally and seriously. I have made a sincere effort to dispel this complacency whenever the opportunity presents itself.

If after reviewing this material, it is determined that additional content is required, please be assured of my cooperation.

Sincerely,

John LaCavera
Staff Development Officer
Justice Institute of B.C.
Corrections Branch

JL/mg

FACTS AND FABLES ON SUICIDE

FABLE: People who talk about suicide don't commit suicide.
FACT: Of any ten persons who kill themselves, eight have given definite warnings of their suicidal intentions.

FABLE: Suicide happens without warning.
FACT: Studies reveal that the suicidal person gives many clues and warnings regarding his suicidal intentions.

FABLE: Suicidal people are fully intent on dying.
FACT: Most suicidal people are undecided about living or dying, and they "gamble with death", leaving it to others to save them. Almost no one commits suicide without letting others know how he is feeling.

FABLE: Once a person is suicidal, he is suicidal forever.
FACT: Individuals who wish to kill themselves are "suicidal" only for a limited period of time.

FABLE: Improvement following a suicidal crisis means that the suicidal risk is over.
FACT: Most suicides occur within about three months following the beginning of "improvement", when the individual has the energy to put his morbid thoughts and feelings into effect.

FABLE: Suicide strikes much more often among the rich or, conversely, it occurs almost exclusively among the poor!
FACT: Suicide is neither the rich man's disease nor the poor man's curse. Suicide is very "democratic" and is represented proportionately among all levels of society.

FABLE: Suicide is inherited or "runs in the family".
FACT: Suicide does not run in families. It is an individual pattern.

FABLE: All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.
FACT: Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy he is not necessarily mentall ill.

*From Some Fact about Suicide by E.S. Shneidman and N.D. Farberow, Washington, D.C., PHS Publication No. 852, U.S. Government Printing Office, 1961.

(Class Handout)

SUICIDE

CAUSES:

- bad news (sickness or death at home, rejection by family, unfaithful spouse)
- being found guilty
- fear of physical abuse from others of a repeated nature
- confinement
- one's guilt arising from the offence committed or fear generated as a result of inmates' displeasure at the nature of the offence
- the young impulsive inmate charged with a violent crime, will often attempt suicide during the first seven days of incarceration (reaction to confinement)
- one who hears or thinks he is mentally ill
- major surgery
- first offenders
- those who have committed a crime of passion

MANIPULATIVE AND IMPULSIVE INMATES:

- to increase his/her contact with others
- to obtain medication
- possibly to plan an escape
- to prompt his/her removal to an area where greater safety from the inmates can be experienced (P.C./Isol.)

SIGNS OF DRUG OR ALCOHOL ABUSE:

- confusion and disorientation
- slurred speech
- very rapid shallow breathing
- lethargy (a condition of abnormal drowsiness)
- cramps, nausea, vomiting, or diarrhea
- sudden collapse
- dilated or pinpoint pupils
- restlessness
- track or needlemarks on arms, legs, or buttocks.
- feeling of being hot or cold

DEPRESSION - PHYSICAL WARNING SIGNS:

- sleeping difficulties; insomnia, irregular hours, early morning awakening
- depressed physical appearance
- walks slowly
- easily fatigued
- weight/appetite loss
- general loss of energy
- slumps when walking or sitting; sits in corner in fetal position

DEPRESSION - BEHAVIORAL WARNING SIGNS:

- cries frequently for no apparent reason
- retarded thinking; speaks slowly; confused communication
- anxiety - physical and mental symptoms; tenseness, restlessness or agitation
- personal appearance; increased dirtiness
- sudden social withdrawal from any external stimulation such as recreation, music, reading, T.V.
- little communication with peer/staff
- apathy and despondency
- aches and pains
- feelings of helplessness and hopelessness
- composes or leaves suicide notes
- talks of self pity
- over-burdened with problems and concerns
- unrealistic release
- gives away personal possessions
- decrease in efficiency and concentration
- change in behavior; sudden unprovoked attack upon officers

HOW TO ACT IN A SUICIDAL SITUATION:

- start a conversation (non-threatening)
- be honest in your response
- do not be judgmental
- do not belittle or make fun
- do not pretend to have all the answers
- talk naturally
- empathy (your humaneness is a critical part of dealing with the crisis)

AT ANY COST DO NOT ARGUE

REFERRAL OF SUICIDAL BEHAVIOR:

If you notice someone who is manifesting either physical or mental symptoms which suggest a potential suicide, it is extremely important that you notify:

- immediate supervisor (P.O./A/P.O.)
- fellow workers (incoming shifts/coffee-lunch reliefs)
- unit/incident report, progress log/medical file
- unit Chaplain

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CHAPTER 2 - SUICIDE

Suicides, both real and attempted are becoming more and more a serious problem.

Since one of your major responsibilities is the safe keeping of a person in custody procedures are needed for those who threaten suicide or who are known to be suicidal. Although most experts agree that a person who really wants to take his life will eventually do so, our branch does, however, have a legal and moral responsibility to prevent suicide if possible. In some situations an officer could be criminally, civilly liable to an inmate/resident, or his/her family, as well as subjected to disciplinary action for negligence of duty, if a suicidal person is injured or dies. Negligent performance of duty might consist of, for example, ignoring obvious signs or intentions of suicide.

Practically every person who kills himself gives some verbal or behavioral clues of his intention to do so, and that the suicidal act rarely occurs without some warning beforehand. An important key to prevention lies in an ability to recognize and assess these clues.

SUICIDAL TYPES

There are four major classifications of suicidal persons in a Correctional Centre and the factors described below will assist you in terms of identifying them:

1. Inmate/Resident Facing A Crisis Situation:

    A. This individual is reacting to a real, immediate problem, such as:

        (1) Bad news (sickness or death at home, rejection by family, unfaithful wife/husband, boyfriend/girlfriend;

        (2) Being found guilty, and receiving an unexpected long sentence;

        (3) Fear of sexual abuse;

        (4) Physical and mental abuse from other inmates/residents of a repeated nature;

        (5) Confinement for a long period in an unsentenced status;

        (6) One's guilt arising from the offence committed or fear generated as a result of inmates/residents displeasure at the nature of the offence.

    B. Feeling shame, disgrace, frustration, and/or hopelessness over a crisis situation. Officers should observe these inmates carefully.

        (1) Bereaved inmates who have suffered a recent loss of a loved one due to divorce or death;

(2) The young, impulsive inmate/resident who is charged with a violent crime often makes a serious suicide attempt of high lethality during the first seven days of incarceration, usually as a reaction to the confinement of an Institutional setting;

(3) The inmate/resident who has been told he/she is mentally ill;

(4) Inmates/residents recuperating from major surgery;

(5) Incarcerated ex-peace officers or professionals;

(6) First offenders;

(7) Those who have committed a crime of passion

2. Person in a Serious Depression:

An inmate/resident defined by experts as being in a "depressed" state mentally does not merely have a case of the "blues". It is normal to react to some problems in life by being temporarily sad or despondent. But a depressed person who is prone to suicide seems to be completely changed by his depression. An officer who sees these signs should (immediately) report his observations.

Depression is a complex feeling, ranging from unhappiness to deep dejection and hopelessness, often accompanied by more or less absurd feelings of guilt, failure, worthlessness, as well as self destructive tendencies. In addition depression has been expressed by many as an extremely painful state. So painful is depression that it is described as a physical symptom.

A. Physical warning signs of serious depression:

(1) Sleeping difficulties: insomnia, irregular hours, early morning awakening;

(2) Depressed physical appearance;

(3) Walks slowly;

(4) Easily fatigued;

(5) Weight loss or loss of appetite;

(6) Slumps when walking or sitting; sits in the corner in fetal position;

(7) General loss of energy

B. Behavioral warning signs of serious depression:

(1) Cries frequently or for no apparent reason, sad, unhappy, and blue;

(2) Retarded thinking; speaks slowly; confused communication;

(3) Perhaps general anxiety, with physical and mental symptoms; tenseness, restlessness or agitation;

(4) Neglect of personal appearance; increased dirtiness;

(5) Sudden social withdrawal from any external stimulation such as recreation, music, reading, television; little communication with inmates/residents or officers;

(6) Apathy and despondency;

(7) Aches and pains;

(8) Feelings of helplessness and hopelessness;

(9) A lot of talk of self pity, of life not being worth it; of people being happier if he/she were to kill themselves; statements, threats and attemps (which indicate a desire to die);

(10) Composes or leaves suicide notes;

(11) Over-burdened with problems, and concerns;

(12) Talks of getting out of the Institution unrealistically;

(13) Gives away personal possessions;

(14) Exhibits sudden changes in behavior, such as making an unprovoked attack upon an officer or another inmate;

(15) Decrease in efficiency and concentration

Occasionally an inmate/resident will become so depressed that he looses touch with reality completely. He may have hallucinations, fear he is sick (hypochondria), or have overwhelming feelings of being "sinful" or worthless. These symptoms may or may not be part of a serious depression, but they are serious mental symptoms, and the inmate should be promptly referred to a physician. The officer should watch for sudden mood changes in which the person goes from depressed behavior to an excited "high" with increased mental and physical activity and an excited state of mind. A person who alternates manic and depressed behavior should be considerd a suicide risk.

3. The narcotic addict or alcoholic who may see suicide as a way out of going through withdrawal:

   A. Causes of death attributed to organic and physical problems:

      (1) Drug overdose;

      (2) Flashbacks from previous psychedelic drug experiences;

      (3) High fever;

      (4) Delirium Tremens (for alcoholics)

   B. Inmates/Residents displaying signs of drug or alcohol abuse:

      (1) Confusion and disorientation;

      (2) Slurred speech;

      (3) Very rapid shallow breathing;

      (4) Lethargy (a condition of abnormal drowsiness);

      (5) Cramps, nausea, vomitting, or diarrhea;

      (6) Sudden collapse

      (7) Dilated or pinpoint pupils

      (8) Restlessness

      (9) Track or needle marks on arms, legs or buttocks;

      (10) Feeling of being hot or cold

   C. Hallucinations:

      (1) Normally experienced by the mentally disturbed inmate/resident;

      (2) Temporarily or permanently lost touch with reality;

      (3) At any given time the mentally disturbed inmate/resident has a possibility of being extremely dangerous and this possibility or risk increases the need to confine or restrict this person for prolonged periods of time;

(4) Quite often we react to the acutely mentally disturbed by isolating them or reducing the sensory environment. This only tends to heighten their fear resulting in a greater increase in their loss of contact with reality. Generally, this person withdraws and deteriorates even further when deprived of contact with others and a reasonable contact with a supportive environment;

(5) Continual withdrawal often leads to a physically acting out behavior towards himself or others;

(6) A show of aggression, either of a suicidal nature or murder, is generally a last desperate effort to prove one's self that contact can still be made with reality. Unfortunately, this last effort may well cost someone his or her life.

The hallucinating inmate/resident will demonstrate the behavior indicating that he is seeing or hearing things that result in extremely scary sensations or instructions for him/her to either kill themselves or in some cases to kill someone else. Extreme care must be taken with all inmates/residents who demonstrate the loss of contact with reality.

4. Manipulative and Impulsive imnates/residents (phony attempts):

It is frustrating for you to try to be professional and concerned about suicide prevention when you know that there are those who use the threat of suicide to manipulate you. Try to remember that anyone who would slash his wrists is emotionally unbalanced and needs professional help.

Manipulative suicidal attempts are often attention-getting efforts on the part of the individual:

(a) To hopefully increase his/her contact with others;

(b) To obtain medication;

(c) Possibly to prompt his removal to an area where greater safety from the inmates/residents can be experienced;

(d) Possibility of a planned escape;

Whenever an attempt is made during the day or before you are due to make your rounds, it is possible that the inmate/resident could be manipulating, since it would appear that he/she is purposely trying to be detected by a staff member.

Many individuals are immature and impulsive; they act without thinking about the consequences of their actions: For the persons who uses suicide as a way of manipulating, this type of behavior can be fatal. . . many dramatic attempts have been made in order to get attention and subsequently some of those persons have tragically lost their lives. Their attempt went further than they anticipated. Therefore, you must never take any attempt at suicide lightly.

THE SUICIDAL PERSON IS DANGEROUS TO OTHERS INCLUDING HIMSELF/HERSELF:-

Often the inmate/resident who is bent on taking his/her life must never be taken for granted. They are potentially dangerous:

(a) They lose sight of socially ordained rules of conduct for themselves, they also tend to loose the same concern for others.

(b) Not infrequently, a suicidal attempt involves injury to innocent bystanders (i.e. fire, gassing, accidents, etc.)

IDENTIFYING THE SUICIDAL RISK:

Should your duties entail admitting the inmates/residents into your centre, you are advised to identify those persons who are likely to become suicidal, and to report your observations immediately. Many suicides often occur within 24 hours of initial admittance. Common sense should prevail:

(a) Anyone obviously under the influence of either drugs or alcohol;

(b) Anyone returning to your centre who has demonstrated suicidal tendencies during previous periods of incarceration;

(c) People who seem to be extremely withdrawn or distant;

(d) Persons who seem very depressed;

(e) Anyone who makes comments such as "What is the use of living anymore?" or "Nobody cares about me anyway!";

(f) Persons who seem overly anxious

PREVENTION:

Remember that the old statement "people who talk about suicide never kill themselves" is untrue. In fact, statistical studies prove that talking about suicide is one of the best predictors that a person will actually try to kill himself/herself. You are making a very serious mistake when you ignore suicide threats. Never invite an inmate/resident to go ahead and kill himself.

You must walk a fine line when faced with a potentially suicidal person. Earlier in this chapter it was pointed out that you must take every threat seriously. Be aware that some individuals may be attempting to manipulate you so that you will take pity and initiate special handling procedures; this person may be "setting" you up to get better quarters or to make an escape attempt.

The real threat with a suicidal inmate/resident is that he may by accident carry through his threat. The person who constantly has the "blues", is sad, weeps and feels unworthy, may actually commit the act even though, underneath it all, he doesn't want to. Prevention is the key. Treat all potentially suicidal persons as if they were sincere, since you are not equipped with any mystical power that would enable you to detect those persons who are sincere and those who are merely trying to manipulate you.

You may be called upon to make some split-second decisions that could result in life or death.

Some will seem completely determined to end their lives but, somewhere within themselves, the spark of desire to live remains. The key for you is to find a way to convince this person he really wants to live before serious damages or death occur. Thus, it is only natural that you would not put this kind of person in a cell on the third or fourth tier of the block. Emile Durkheim, a well known French sociologist and philosopher, commented that in his belief, individuals contribute to their self worth. The result is a breakdown in social integration. They become "lost" people whose only device for solving the problem is to commit suicide. The trick for you is to reactivate that contact with the real world and the people in it as quickly as possible.

PROFILE OF SUICIDE VICTIMS:

Age: As a general rule, the older the person, the more likely that he will be successful in the suicide. There are twice as many people who attempt suicide in the 20-30 age group. This is changing somewhat though; in recent years, there has been a significant increase in suicide in the 15-19 age group.

Sex: Women attempt suicide much more frequently than do men; however, men have a higher rate of actual suicide. The average ratio seems to be for every three women who attempt suicide and fail, one woman succeeds. With men, the ratio is reversed. For every man who attempts and fails, there are three men who succeed. It has been suggested that in our society suicidal gesturing among men is considered a sign of weakness. Therefore, a suicide threat or attempt is less a cry for help and more apt to be the real thing when the victim is a male. In addition, men primarily employ means in which there is a point of no return rapidly reached. For that reason, men will use firearms or hanging more often, while women will ingest some type of toxic substance which allows for attempts to save them if they are discovered and taken to a hospital quickly enough to have their stomachs pumped.

Marital Status: There doesn't seem to be any apparent difference in the successful suicide rate between those who are married and those who are single. There is, however, a difference between those groups and those who are separated, widowed, or divorced. In general, the rate of suicide is four times higher for those in the second group than those in the first.

MYTHS ABOUT SUICIDE:

Discussion of death, and particularly suicide, has always been more or less taboo in our society. Consequently, most people accept certain misconceptions about suicide as truth.

Should you believe in these misconceptions particularly when you have contact with suicidal persons it can only be detrimental and must be recognized and dealt with if successful intervention is to be achieved. For example, it is a common misconception that if a suicidal inmate/resident appears to have passed his suicidal crisis that the suicide risk is over and he/she is out of danger. On the contrary, research indicates that half of the persons who were in a suicidal crisis, and subsequently committed suicide, did so within 90 days of having passed the emotional crisis and after they appeared to be on their way to recovery.

Any inmate/resident exhibiting behavioral change such as an improvement during such a suicidal crisis should be CAREFULLY WATCHED as this is a very CRITICAL PERIOD.

Following are common misconceptions or fables about suicide and the appropriate facts which apply.

FABLE	FACT
Suicide happens suddenly and impulsively without premeditation.	Less than five percent of suicides result from impulsive panic-type behavior. More often than not the suicidal thought arises as a fantasy to resolve some personal crisis.
The suicidal person rarely reveals or conveys his intentions to anyone else.	Of the ten persons who kill themselves, eight have given definite warnings of their suicidal intentions.
Once a persons attempts suicide and fails, this minimizes the possibility of a future attempt because the inmate has "gotten it out of his system".	Eighty percent of persons who kill themselves have made at least one previous attempt.
The suicidal act is a logical, well thought out expression of an attempt to cope with serious personal problems.	Most suicidal persons are irrational at the time of their suicidal crisis. This person has ambivalent feelings; he wants to live. However, overwhelmed with despair, anxiety, and hopelessness, he cannot see any other solutions to his problems.

FABLE	FACT
Suicides happen much less frequently in a Correctional-type setting than in the non-prison population (outside the Correctional Environment).	Correctional suicides occur 3 1/2 times more frequently than suicide in the non-prison population.
If someone says they want to kill themselves there is usually no way to prevent it.	Most suicidal persons are ambivalent; they are miserable but they wish to be saved.

TALKING TO AN INMATE/RESIDENT WHO MAY BECOME SUICIDAL:

One of the most important reasons for an officer to be attentive to the emotional needs of an inmate/resident is that this person may not be suicidal yet. He/she could be desperately searching for a reason to live and seeking help. Denial on the part of the officer of the individual's problem and withdrawal or lack of attention could literally cause this individual to decide to kill himself. The officer who ignores a suicidal person could confirm the inmate's/resident's feelings that his life is not worth living and that death is the only answer to his problems.

An officer will not endanger a persons life by discussing his suicidal thoughts; on the contrary, the officer will encourage verbalization, which is desired. All cries for help are genuine and cannot be measured by the apparent seriousness of the threat.

HOW TO ACT IN A SUICIDAL SITUATION:

The natural tendency is to rush in and make an immediate rescue. All too frequently, however, unwise, unplanned action leads to injury or death. The officer should keep in mind that if the death is imminent, there is little he can do to prevent it. His first step is to assess any threats to his own safety or to that of others.

The officer should secure the area as quickly as possible. This includes moving the inmates into another housing area or out of the area where the suicide incident is taking place. The officer should try to position himself so that he has line-of-sight vision with the suicidal inmate. He should also make sure entrances are cleared for others who will assist him.

The important thing is to start a conversation with the suicidal inmate/resident that is non-threatening. A person intent on suicide needs to feel that he is in complete control of the situation. Therefore, it is essential that the officer not act in any manner that could be considered threatening. A part of the battle is won as soon as conversation begins. By such reassurances from the officer as "OK, you're calling the shots, we'll listen to you," the suicidal inmate is encouraged to release some of this emotion.

It is essential that the officer be attentive and listen to the person. He should use facial and body gestures to encourage the person to talk until the officer feels comfortable enough to enter the conversation. The following guidelines should be helpful:

(1) The officer should be honest in his responses.

(2) He should not be judgmental.

(3) He should try to understand the suicidal persons point of view; your humaness with this person is a critical part of dealing with the crisis.

(4) He should not belittle or make fun of the inmate/resident.

(5) Don't pretend to have all the answers.

(6) He should try to talk naturally with the inmate/resident.

(7) At any cost do not argue.

If the situation allows, after a conversation is being conducted as naturally as possible, the officer should attempt to suggest that there are other, more acceptable ways to solve the problem, especially if the person is trying to kill himself to "get back" at someone else for a personal injury or insult. The officer should recognize the persons anger and disgust and "legitimize" it while offering a better alternative.

THE OFFICER WHO DISCOVERS A GENUINE HANGING ATTEMPT SHOULD:

(1) Summon for assistance, having regard to unit policy.

(2) Extricate the victim, protecting his head and neck as much as possible.

(3) Have someone call for an ambulance immediately.

(4) Give basic first aid. This includes:

   A. Monitor and maintain open airway -

      a) Look, listen, and feel for breathing if he is unconscious

      b) Maintain airway, if necessary, using the modified jaw thrust technique. DO NOT tilt the head back.

         (i) Place your fingers behind the angles of lower jaw

         (ii) Forcefully bring his jaw forward

         (iii) Use your thumbs to pull his lower lip down to allow breathing through the mouth as well as the nose

c) Give artificial respiration, if necessary, while continuing maintenance of airway through jaw lift.

B. If there is no pulse, give cardiopulmonary resuscitation; if trained.

C. Assume that he has spinal cord injury, and treat appropriately:

a) Place victim flat on floor with head held stable

b) Do not let victim or anyone else lift or twist his head

c) Give him nothing to eat or drink, and no medications

D. If there is swelling or discoloration, apply an ice bag to the area.

E. Do not leave the victim alone.

Officers should always remember that any suicide attempt is a serious matter.

AWARENESS AND REFERRAL OF SUICIDAL BEHAVIOR IS CRUCIAL:

An inmate/resident who is serious about committing suicide will try to estimate a time to carry out his plan when the likelihood of being discovered by someone is small. For this reason the officer should make unsystematic patrols of the tier/dorm. This will hinder the persons efforts at timing him and increase the possibility of successful intervention.

Because the largest percentage of suicides occur between the hours of 12 midnight and 8 a.m., this tour must be extra observant and aware of suicidal potential. Persons suffering from insomnia or sever states of depression should be kept under close observation. The importance of untimed frequent patrols is even more crucial on this shift. In addition ensure you can see skin and that he or she is breathing. Don't be hasty.

If you notice an individual who is manifesting either physical or mental symptoms which suggest a potential suicide, it is extremely important that you notify:

- Immediate Supervisor (Principal Officer/Senior Youth Supervisor)
- Fellow Workers/including those who replace you for coffee/lunch periods
- Ensure incoming shift is made aware of the situation
- Unit report/incident report
- Inmates/residents progress log (*remember you are not a physciatrist therefore, it is valuable that you record your observations only. avoid medical terms)

EMPATHY:

Please note: empathy doesn't mean the same thing as sympathy.

The term is important as a way of interacting with inmates regardless of how manipulative they might be. It helps to be able to clearly distinguish between the desire to assist another to become responsible for himself and the desire to sympathize with the other's ability to cope with his present life situation.

Many individuals may not be highly "lethal", that is, they may not be ready to end their lives within minutes. Remember the suicidal inmates/residents you will be dealing with most likely are crying out, or who are trying to manipulate a painful environment the best way they know how. Regardless of your feelings, lower risk inmates/residents need intervention.

"There isn't any effort too great in order to save a human life".

SUMMARY:

1. Suicides, both real and attempted, are a significant problem for Correctional Personnel; since officers are responsible for preventing suicides, they must be able to recognize the symptoms of suicide and take the proper steps to intervene.

   Officers should consider all suicide threats by inmates/residents to be serious and take appropriate steps to prevent them from carrying out his threats. This includes constant observation. Officers should recognize the symptoms of potential suicide, such as depression or a sudden change in behavior, and attempt to find out what is troubling the person. It is a serious mistake for officers to ignore suicide threats or invite a person to go ahead and kill himself/herself. Prevention is the key.

2. If an officer discovers an inmate/resident attempting to kill himself, the most important step the officer can take in most cases is to start a conversation with the inmate that is non-threatening.

   A persons who is actually attempting suicide needs to feel that he is in complete control of the situation. Therefore, it is essential that the officer not act in any manner which could be considered threatening. The officer should encourage the person to talk and gradually enter the conversation himself. He should be honest in his responses to the person and should not be judgmental. Nor should he belittle the person or make fun of him/her. However, if the officer arrives upon the scene too late to prevent an inmate/resident from carrying out a suicide attempt, such as a hanging, the officer should act immediately to rescue the person.

CRISIS INTERVENTION:

COURSE DATES:

1 June - 4 June 1982
7 Sept. - 10 Sept. 1982
4 Jan. - 7 Jan. 1983

COURSE OBJECTIVES:

- Identify prevailing signs and symptoms of potential crisis situations.

- Demonstrate an understanding of preventing and/or dealing with crisis situations.

- Demonstrate an understanding of physiological and psychological effects of stress and ways to cope with personal stress.

- Demonstrate an understanding of suicide causes, hostage situations and hostage survival techniques.

CONTENT DESCRIPTION:

This four day course will focus on preventive tactics as well as effective methods of handling crisis situations.

E: basic (R)P: 11

ATTENDANCE CRITERIA:

Completion of Basic Security Officer Training. Special consideration will be given to other Branch employees requiring crisis management training.

INTERVIEWING AND MOTIVATING SKILLS:

COURSE DATES:

6. There are many possible causes of suicide. List two causes which may attribute to suicide in a correctional centre.

a) ______________________________

____

b) ______________________________

____

7. List two possible reasons for a manipulative suicidal attempt.

a) ______________________________

____

b) ______________________________

____

8. Officers must never take a manipulative suicidal attempt for granted. Explain why?

____

____

____

____

9. List three physical warning signs of serious depression.

a) ______________________________

____

b) ______________________________

____

c) ______________________________

____

10. If you notice a resident who is manifesting either physical or mental symptoms which suggest a potential suicide, who would you notify immediately?

____

____

____

- APPENDIX H -

The Prevention of Suicide in Prison

Student's Handbook

Published by the
Communications Branch for
Medical and Health Care Services

Ottawa, January 1981

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- APPENDIX I -

3.4 Conclusions

We can draw the following conclusions from the analysis.

Conclusion 1:

Suicides occur at a higher rate in maximum security institutions than in medium security institutions. There are virtually no suicide incidents in minimum security institutions.

Conclusion 2:

There is a much higher rate of suicide in the dissociation areas than in the general cells; however, because the majority of inmates are in general cells, that is where the largest number of suicides take place.

Conclusion 3:

Unlike the case for non-fatal self inflictors, age is not correlated with suicide rate.

Conclusion 4:

Suicides occur at a higher rate among individuals with either little education or post high school education.

Conclusion 5:

The rate of suicide among inmates who have committed a crime against another person is greater than the rate among inmates who committed property crimes.

Conclusion 6:

There is little relationship between suicide and marital status, but married inmates may have a slightly lower rate than the others.

Conclusion 7:

There is little relationship between suicide and I.Q., sentence length, or time since admission to the system.

Conclusion 8:

The favored method of suicide is hanging, although less than one hanging attempt in five results in a successful suicide.

2.10 General Profile Of A Self-Inflictor

In comparing profiles it is clear that the self-inflictor differs significantly from the average inmate in relatively few ways. The self-inflictor tends to be younger than average, with the most likely age being 24. Women may be more likely to self-inflict than men but there was insufficient information to draw a firm conclusion on this contention. On average the self-inflictor is less likely to be married than the non-self-inflictor. However, a self inflictor could easily have a common law relationship. When we look at the regional statistics we see that there is little relationship between language and self-inflicted injury. Sexual deviation, as measured by a history of sex crimes, does not have a statistically significant role to play. It is clear that self-inflictors injure themselves early in their stay at a particular institution. However, at the time of the self-infliction the self-inflictor had been in the system a relatively long time. Also, self-inflictors tend to have a history of alcohol and drug abuse and are very likely to be repeat offenders. They have less education than the average inmate but are generally considered to be of average intelligence.

2.11 Conclusions

In addition to the conclusions implicit in the profile in section 2.10 we have the following:

Conclusion 2:

The incidence of self-inflicted injury is significantly greater in maximum security than in medium security institutions. The self-inflicted injury phenomenon is virtually non-existent in mininum security institutions.

Conclusion 3:

The Pacific and Atlantic Regions have the highest incidence of self-inflicted injury followed by the Prairie Region, Quebec and Ontario in that order. Quebec is about average for Canada in terms of self-inflicted injury rates. This finding runs counter to the notion that rates are highest in Quebec. A more accurate reporting of incidents in Quebec combined with incomplete reporting elsewhere led to this erroneous conclusion.

Conclusion 4:

The Security Reporting System in all Provinces except Quebec substantially underreports self-inflicted injuries.

Conclusion 5:

On a rate per inmate-year served basis, self- inflicted injury is much more common in segregation and special handling units, and somewhat more common in protective custody units than in the general cell population. In spite of this, because of the large prisoner population in the general cells, more than half of all self- inflicted injuries occur in the general cells.

Conclusion 6:

The majority of all self-inflicted injuries are minor or moderate in nature.

Conclusion 7:

Attempts at suicide are relatively more frequent in segregation and special handling units than in protective custody and the general cells.

Conclusion 8:

Self-Inflictors in dissociation areas and in the general cells differ little from each other.

Conclusion 9:

Self-inflicted injuries tend to occur relatively soon after admission to a given institution but a fair length of time after admission into the system.

Conclusion 10:

The self-inflictor and non-self-inflictor profiles developed in this report show that differences between these groups are minimal and therefore self-inflictors are not readily identified from the general population.

- APPENDIX J -

Distribution List

April 2, 1982

File No. 106-000-3

Re: Suicides - General

As you may be aware, a study pertaining to suicides is underway in the Branch.

Very briefly, We are interested in obtaining any existing, written, local policy you have covering this topic, in particular:

a) identification of potential types;
b) observation/surveillance procedures;
c) training of staff respecting a) and b);
d) medical or other procedures.

We are only interested in obtaining what exists now at your centre. In the event Mr. Bob Collins, L.M.R.C.C., has already contacted you, please note below and return.

A reply to the undersigned, by return mail, would be appreciated.

Cain

J.V. Cain
Director
Inspection & Standards

cc. Regional Directors

CENTRE: ______________________

☐ **Material enclosed.**

☐ **Already submitted to Mr. Collins.**

☐ **No policy in existence.**

______________________ ______________________
(Signature) **(Title)**

- APPENDIX K -

COMMENT DATA SCREEN

A new prompt, "CD", has been added to most Provincial Case File screen displays. This prompt allows access to the Comment Data screen, which contains subjective and objective comments on each Provincial Case File record.

The format for the Comment Data screen is as follows:

```
 (1)    (2)                  (3)                               (4)
Date   Code               Comment                            Author

131082  --  ------------------------------------------------------------
------------------------------------------------------------------------
-------------------------------------------------------------- D.D'ARGIS

ENTER A, C--, D-- (--=+) OR A NEW TRANSACTION ID              SELECT:(5)
```

1. DATE	The date that the comment was entered. Date is automatically entered by the computer.
2. CODE	The two-character code which categorizes the type of comment. Code values include: ES - Escape alert ME - Medical alert SU - Suicide alert VI - Violent alert RE - Probation reports comment FI - Probation file location/microfilmed comment SP - Probation special reporting conditions OP - Other probation comment CL - Other classification comment IS - Other Inspection and Standards comment OI - Other institution comment DS - Data Services comment
3. COMMENT	Each comment can contain up to 198 characters (3 lines) of alphabetic or numeric text. DO NOT ENTER DATA IN THE LAST TWO CHARACTERS OF THE COMMENT FIELD. The space is reserved for the future development of an "Expiry Date" which can be set by the author.

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BIBLIOGRAPHY

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POOR

QUALITY

ORIGINAL